MENTAL HEALTH SERVICES ACT

Three-Year Program and Expenditure Plan, Fiscal Year (FY) 2023-24 to 2025-26 & Annual Update, FY 2023-24

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

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BEHAVIORAL HEALTH & RECOVERY SERVICES

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May 31, 2023

Greetings and thank you to all involved in the development of this year's Mental Health Services Act (MHSA) Three-Year Plan, Fiscal Year 2023-24 through 2025-26!

This MHSA Three-Year Plan includes the perspective of over 400 individuals including clients and family members, community members and leaders representing diverse geographical, ethnic, and cultural backgrounds, contracted providers, County staff, and other partner agencies across health, social services, education and other sectors. Individuals participated via workgroups, input sessions, surveys, public meetings, video testimonials and public comments. This level of support is not only commendable, but also reflective of our collective commitment and interest in improving our behavioral health system and ensuring that MHSA funding is prioritized for some of the most pressing gaps.

BHRS' mission includes providing prevention, treatment and recovery services to inspire hope, resiliency and connection with others and enhance the lives of those affected by mental health and/or substance use challenges. The MHSA Three-Year Plan embodies just that as it prioritizes important strategies across continuums and in genuine partnership with communities. Priority strategies that are included in this plan address access to care for marginalized communities; expand and improve Full Service Partnerships model of care; support clinician-led non-armed crisis response teams; and invest in behavioral health workforce recruitment, pipelines, retention, training and continuing education opportunities for our workforce, contracted providers and peers. We need to ensure we have a strong, resilient workforce!

We are going into the next three-years with unprecedented MHSA revenue increases, it is exciting to be able to expand services. It is also very timely as we are entering a time of significant demands on public behavioral health systems including the implementation of payment reform under the California Advancing and Innovating Medi-Cal (CalAIM) program, implementation of a new required Community Assistance, Recovery and Empowerment (CARE) Court, a nationwide behavioral health workforce shortage, all while we experience increased behavioral health needs post pandemic, and a potential complete overhaul of MHSA with the Governor's Proposal to Modernize Behavioral Health Systems.

We need you to remain a strong partner in this work! I look forward to working alongside with you as we go into the next three-years of MHSA implementation. Thank you for taking the time to review and provide your input. Public Comments can be submitted via email to MHSA@smcgov.org

Sincerely,

Dr. Jei Africa, MSCP, CATC-V, FACHE
Director, San Mateo County Health, Behavioral Health & Recovery Services

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MHSA COUNTY COMPLIANCE

*This section to be completed after Board of Supervisor adoption of the Three-Year Plan

MHSA COUNTY FISCAL ACCOUNTABILITY COMPLIANCE

*This section to be completed after Board of Supervisor adoption of the Three-Year Plan

INTRODUCTION

INTRODUCTION TO SAN MATEO COUNTY

Located in the Bay Area, San Mateo County is bordered by the Pacific Ocean to the west and San Francisco Bay to the east. The County was formed in April 1856 out of the southern portion of then-San Francisco County. Within its 455 square miles, the County is known for a mild climate and scenic vistas. Nearly three quarters of the county is open space and agriculture remains a vital contributor to the economy and culture. The County has long been a center for innovation. Today, San Mateo County's bioscience, computer software, green technology, hospitality, financial management, health care and transportation companies are industry leaders. Situated in San Mateo County is San Francisco International Airport, the second largest and busiest airport in California, and the Port of Redwood City, which is the only deep-water port in the Southern part of the San Francisco Bay. These economic hubs have added to the rapidly growing vitality of the County.

COUNTY OF SAN MATEO MISSION

San Mateo County government protects and enhances the health, safety, welfare and natural resources of the community, and provides quality services that benefit and enrich the lives of the people of this community. We are committed to:

- The highest standards of public service;
- A common vision of responsiveness;
- The highest standards of ethical conduct;
- Treating people with respect and dignity.

The County is committed to building a healthy community. The County of San Mateo Shared Vision 2025 places an emphasis on the interconnectedness of all communities, and specifically of county policies and programs. Shared Vision 2025 is for a sustainable San Mateo County that is 1) healthy, 2) prosperous, 3) livable, 4) environmentally conscious, 5) collaborative community. This MHSA Three-Year Plan supports goal #1; a healthy community where the vision is that neighborhoods are safe and provide residents with access to quality health care and seamless services.

BEHAVIORAL HEALTH AND RECOVERY SERVICES

Behavioral Health and Recovery Services (BHRS), a division of San Mateo County Health, provides services for residents who are on Medi-Cal or are uninsured including children, youth, families, adults and older adults, for the prevention, early intervention, and treatment of mental illness and/or substance use conditions. We are committed to supporting treatment of the whole person to achieve wellness and recovery, and promoting the physical and behavioral health of individuals, families and communities we serve.

The following statements were developed out of a dialogue involving consumers, family members, community members, staff and providers sharing their hopes for BHRS.

The Vision: We envision safer communities for all where individuals may realize a meaningful life and the challenges of mental health and/or substance use are addressed in a respectful, compassionate, holistic and effective manner. Inclusion and equity are valued and central to our work. Our diverse communities are honored and strengthened because of our differences.

The Mission: We provide prevention, treatment and recovery services to inspire hope, resiliency and connection with others to enhance the lives of those affected by mental health and/or substance use challenges. We are dedicated to advancing health and social equity for all people in San Mateo County and for all communities. We are committed to being an organization that values inclusion and equity for all.

Our Values

Person and Family Centered: We promote culturally responsive person-and-family centered recovery.

Potential: We are inspired by the individuals and families we serve, their achievements and potential for wellness and recovery

Power: The people, families and communities we serve, and the members of our workforce guide the care we provide and shape policies and practices.

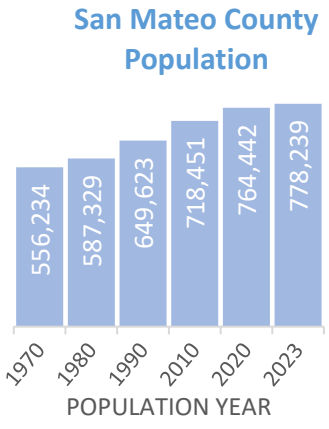
Partnerships: We can achieve our mission and progress towards our vision only through mutual and respectful partnerships that enhance our capabilities and build our capacity

Performance: We use proven practices, opportunities, and technologies to prevent and/or reduce the impacts of mental illness and additions and to promote the health of the individuals, families and communities we serve.

SAN MATEO COUNTY DEMOGRAPHICS - 2023

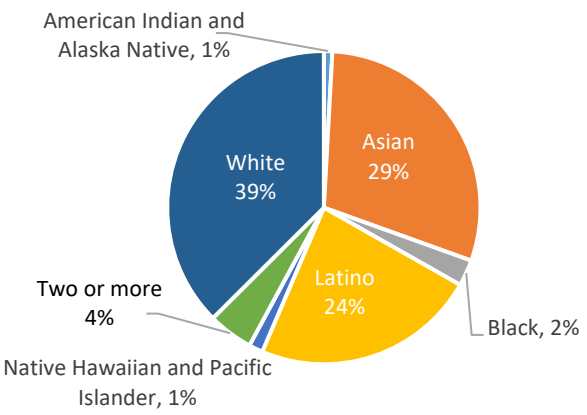
The estimated population of San Mateo County, according to the most recent U.S. Census Bureau data, is 778,239 – a 6.7% jump over the 2010 Census. Daly City remains the most populous city followed by San Mateo and Redwood City.

The estimated median age of residents is 39.8 and a median household income of $128,091. While The town of Portola Valley has the highest median age of 51.3 years while East Palo Alto a much less affluent community has the lowest at 28.1 years; an indicator of health inequities.



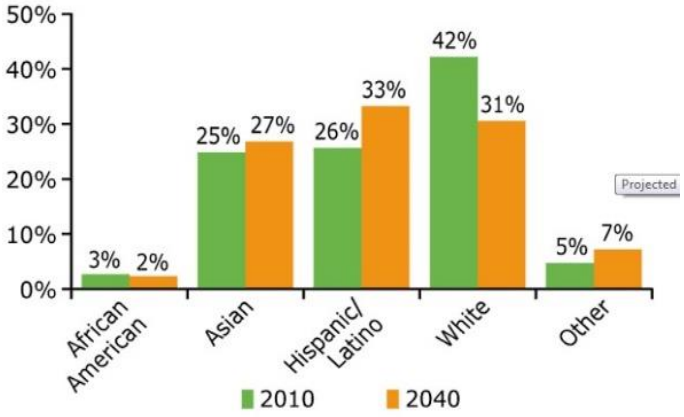
As the County's population continues to shift, it continues to grow in diversity. 45.57% of residents speak a language other than English at home, and 35.01% are foreign born. San Mateo County's threshold languages are Spanish, Chinese (Mandarin and Cantonese), Tagalog and Russian (as identified by Health Plan of San Mateo). County Health identified Tongan, Samoan as priority languages based on a growing number of clients served and emerging languages as Arabic, Burmese, Hindi, and Portuguese.

San Mateo County Population by Race/Ethnicity



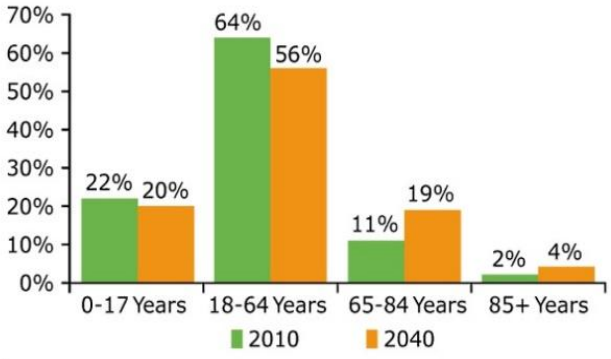
By 2040, San Mateo County is projected to have a majority non-White population. The White population is projected to decrease by 11%. The Latino and Asian communities are projected to increase by 7% and 2%, respectively[1]. Additionally, the projected population by age group shows that residents 65 and older are projected to almost double.

Projected Population by Race/Ethnicity
San Mateo County, 2010 and 2040



Data Source: State of California, Department of Finance

Projected Population by Age Group
San Mateo County, 2010 and 2040



Data Source: State of California, Department of Finance

[1] sustainablesanmateo.org

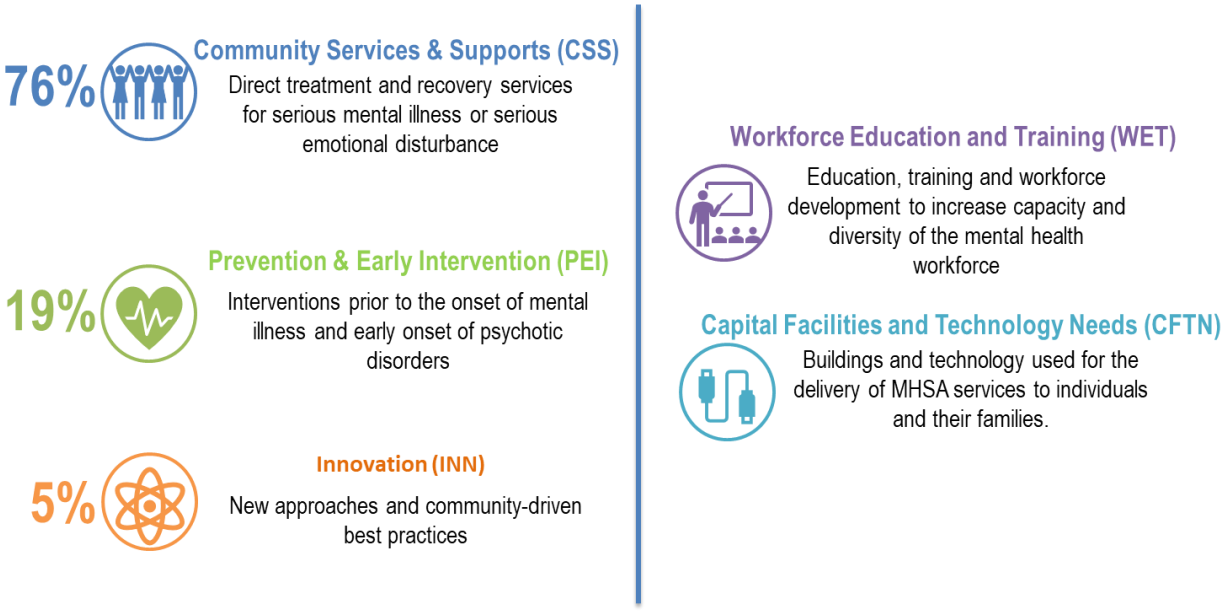
MHSA BACKGROUND

Proposition 63, the Mental Health Services Act (MHSA), was approved by California voters in November 2004 and provided dedicated funding for mental health services by imposing a 1% tax on personal income over $1 million dollars. San Mateo County received an annual average of $39.2 million, in the last five years through Fiscal Year (FY) 2021-22.

MHSA emphasizes transformation of the behavioral health system, improving the quality of life for individuals living with behavioral health issues and increasing access for marginalized communities. MHSA planning, implementation, and evaluation incorporates the following core values and standards:

◆ Community collaboration ◆ Cultural competence ◆ Consumer and family driven services
◆ Focus on wellness, recovery, resiliency ◆ Integrated service experience

MHSA provides funding for Community Program Planning (CPP) activities, which includes stakeholder involvement in planning, implementation and evaluation. MHSA funded programs and activities are grouped into "Components" each one with its own set of guidelines and rules:



COMMUNITY PROGRAM PLANNING

COMMUNITY PROGRAM PLANNING (CPP)

BHRS promotes a vision of collaboration and integration by embedding MHSA programs and services within existing infrastructures. San Mateo County does not separate MHSA planning from its other continuous planning processes. Given this, stakeholder input from system-wide planning activities is considered in MHSA planning. The Mental Health and Substance Abuse Recovery Commission (BHC), the local "mental health board", is involved in all MHSA planning activities providing input, receiving regular updates as a standing agenda item on their monthly meetings, and making final recommendations to the San Mateo County Board of Supervisors (BOS) on all MHSA plans and updates.

MHSA STEERING COMMITTEE

The MHSA Steering Committee continues to play a critical role in the development of MHSA program and expenditure plans in San Mateo County. The MHSA Steering Committee makes recommendations to the planning and services development process and as a group, assures that MHSA planning reflects local diverse needs and priorities, contains the appropriate balance of services within available resources and meets the criteria and goals established. The Steering Committee meetings are open to the public and include time for public comment as well as means for submission of written comments.

MHSA Steering Committee Roles and Responsibilities were developed to strengthen the representation of diverse stakeholders by including member composition goals related to stakeholder groups (e.g., at least 50% represent clients/consumers and families of clients/consumers; at least 50% represent marginalized cultural and ethnic groups; maximum of two member representatives from any one agency, etc.). In response to ongoing feedback from stakeholders the MHSA Steering Committee was established as a Standing Committee of the Behavioral Health Commission (BHC), San Mateo County's local mental health board, which requires the appointment of 1-2 chairperson(s) to the committee. The MHSA Steering Committee meets four times per year in February, May, September and December. All MHSA Steering Committee meeting materials including slides, minutes and handouts can be found on the MHSA website, www.smchealth.org/MHSA, under the MHSA Steering Committee tab.

Fiscal Year (FY) 2022-23 MHSA Steering Committee Members

Stakeholder Group	Name	Title (if applicable)	Organization/Affiliation (If applicable)
Family Member	Jean Perry	MHSA Co-chairperson	Behavioral Health Commission, Lived Exp Education Workgroup
Public	Leticia Bido	MHSA Co-chairperson	Behavioral Health Commission
Client/Consumers	Jairo Wilches	Program Coordinator	BHRS, Office of Consumer and Family Affairs (OCFA)
Client/Consumers	Michael S. Horgan	Program Coordinator	Heart & Soul, Inc.
Cultural Responsiveness	Maria Lorente-Foresti	Director	BHRS, Office of Diversity and Equity (ODE)
Cultural Responsiveness	Kava Tulua	Executive Director	One East Palo Alto
Education	Mason Henricks	Administrator	SMC Office of Education
Family Member	Chris Rasmussen	Chair	Behavioral Health Commission
Family Member	Juliana Fuerbringer	Board Member	California Clubhouse
Health Care	Eddie Flores	Director of Youth Behavioral Health	Peninsula Health Care District
Health Care	Jessica Ho/ Vivian Liang	Govt and Community Affairs Manager	North East Medical Services
Other - Peer Support	ShaRon Heath	Executive Director	Voices of Recovery
Provider of Behavioral Health Services	Adriana Furuzawa	Division Director	Family Service Agency
Provider of Behavioral Health Services	Melissa Platte	Executive Director	Mental Health Association
Provider of Behavioral Health Services	Mary Bier	Coordinator	North County Outreach Collaborative
Public	Michael Lim	Commissioner	Behavioral Health Commission, Lived Exp Education Workgroup
Public	Paul Nichols	Commissioner	Behavioral Health Commission
Public	Sheila Brar	Commissioner	Behavioral Health Commission

STAKEHOLDER ENGAGEMENT

MHSA Steering Committee meetings are open to the public and diverse stakeholder participation is promoted through various means, including flyers, emails, announcements, postings, community partners, clients/consumers, community leaders, and the general public. The following demographics represents unique participants in MHSA Steering Committee meetings in FY 2022-23. When comparing race/ethnicity demographics to San Mateo County census data, all but Asian are comparable. Asian communities are underrepresented by 10%, compared to 15% underrepresentation in 2020. While there has been some improvement in Asian community engagement in recent years with the addition of a North East Medical Services (a.k.a. the “Chinese Hospital”) representative on the MHSA Steering Committee, there

continues to be a need for improvement. Communities of color are engaged in MHSA planning via the Office of Diversity and Equity's Health Equity Initiatives, which represent 9 cultural and ethnic groups including: African American Community Initiative, Chinese Health Initiative, Filipino Mental Health Initiative, Latino Collaborative, Native and Indigenous Peoples Initiative, Pacific Islander Initiative, PRIDE Initiative, Spirituality Initiative, and the Diversity and Equity Council.

San Mateo County Census Race/Ethnicity		Steering Committee Participation Race/Ethnicity	
Asian	29%	Asian Indian/South Asian, Chinese, Filipino*	19%
Black or African American	2%	Black/African-American	4%
Hispanic or Latino	24%	Hispanic/Latino/x	19%
Native Hawaiian or Pacific Islander	1%	Native Hawaiian or Pacific Islander	2%
White alone, not Hispanic	39%	White/Caucasian	43%
Two or More	4%	Two or More*	9%
		Another Race/Ethnicity	3%

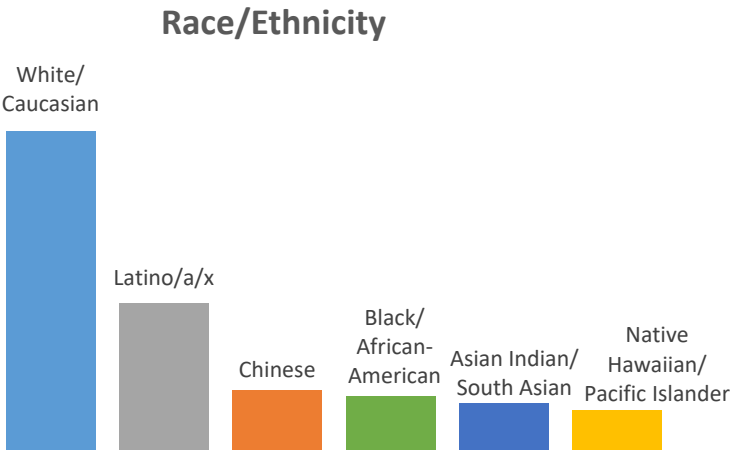
** Combined to allow for comparison as per MHSA legislation but, represented uniquely below*

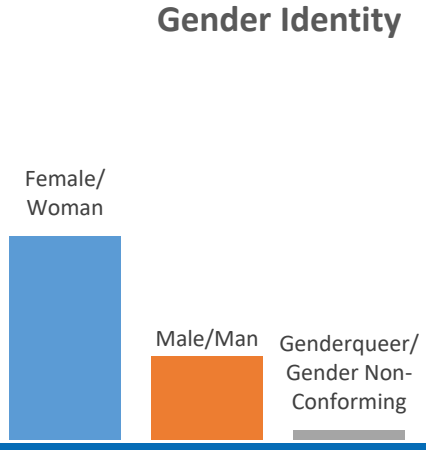
MHSA Steering Committee Participant Demographics

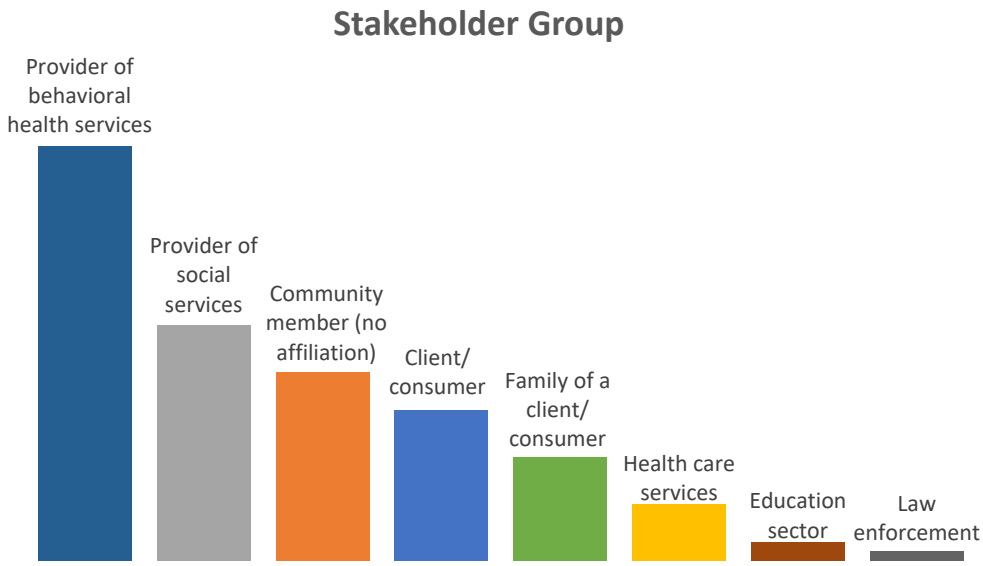
- Combined for Sep '22, Dec '22, Feb '23 and May '23

What is your age range?	
16-25	6%
26-59	73%
60+	21%

What part of the county do you live in or work in?	
Central County	26%
North County	24%
South County	17%
Coast	7%
County-wide	17%
East Palo Alto/Belle Haven	4%
N/A (outside of County)	5%







Peer, Client/Consumer and Family Engagement in MHSA

MHSA is committed to engaging individuals with lived experience in planning, implementation and evaluation. Participation and expertise of individuals with lived experience is promoted and compensated with stipends. For the FY 2021-22 reporting year of the enclosed MHSA Annual Update, the following stipends were provided to clients and family members of clients participating in MHSA-funded activities. Stipends distributed almost doubled, compared to last reporting year ($11,120). During the MHSA Three-Year Plan Community Program Planning (CPP) process, 35 stipends ($1,050) were provided to clients/consumers and families of clients/consumers for their participation.

Activity (FY 2021-22)	Stipend $ Amount Distributed	# Unique recipients
Health Equity Initiatives	$5,700	36
Help@Hand – WYSA	$2,820	20
MHSA FSP	$360	4
Lived Experience Education Workgroup	$4,230	26
Women's Conference	$1,020	6
Advocacy Council	$2,790	14
Advocacy Academy	$2,040	9
Mental Health Awareness Month	$390	9
MHSA Steering Committee	$90	3
Diversity and Equity Council	$600	6
Suicide Prevention Planning	$1,800	14
TOTAL	$21,840	

30-DAY PUBLIC COMMENT AND PUBLIC HEARING

MHSA legislation requires counties to prepare and circulate MHSA plans and updates for at least a 30-day public comment period for stakeholders and any interested party to review and comment. Additionally, the Behavioral Health Commission (BHC) conducts a public hearing at the close of the 30-day comment period.

The Three-Year Program and Expenditure Plan FY 2023-24 through FY 2025-26 and Annual Update FY 2023-24 with data from FY was presented on June 7, 2023, to the BHC. The BHC voted to open a 30-day public comment period and held a Public Hearing. On July 5, 2023, the BHC reviewed the public comments received, voted to close the public comment period on July 7, 2023, and to submit the Three-Year Plan and Annual Update to the Board of Supervisors. Please see Appendix 1 for the presentation materials to the BHC and all public comments received. *[To be updated after the closing of the 30-day public comment process]*

The Three-Year Plan and Annual Updates are submitted to the San Mateo County local Board of Supervisors for adoption and to the County of San Mateo Controller's Office to certify expenditures before final submission to the State of California Mental Health Services Oversight and Accountability Commission (MHSOAC) and the Department of Health Care Services (DHCS).

Various means are used to circulate information about the availability of the plan and request for public comment and include:

- Announcements at internal and external community meetings
- Announcements at program activities engaging diverse families and communities (Parent Project, Health Ambassador Program, Lived Experience Academy, etc.)
- E-mails disseminating information to an MHSA distribution list of over 2,400 subscribers; and the Office of Diversity and Equity distribution list of over 2,100 subscribers
- Word of mouth on the part of committed staff and active stakeholders
- Posting on the MHSA webpage smchealth.org/MHSA, the BHRS Blog, smcbhrsblog.org, and the BHRS Director's Update, https://www.smchealth.org/post/directors-update, which reaches over 2,600 subscribers

CPP FRAMEWORK & PROCESS

The MHSA Three-Year is developed in collaboration with clients and families, community members, staff, community agencies and stakeholders. In November 2022, a comprehensive Community Program Planning (CPP) process to develop the MHSA Three-Year Plan commenced. Planning was led by the MHSA Manager, Behavioral Health Commission MHSA Co-Chairpersons, an MHSA Three-Year Plan Workgroup and the MHSA Steering Committee. A draft CPP process was provided to the BHC on December 7, 2022. The BHC was asked for their input and comments on the process and what additional stakeholder groups should be engaged.

CPP FRAMEWORK

MHSA THREE-YEAR PLAN WORKGROUP

The MHSA Steering Committee hosts up to two small workgroups per year focused on a specific MHSA topic that is aligned with MHSA planning needs. The workgroups are open to public participation, are time-limited and 10-12 participants are selected via an interest survey.

Between November and January 2023, a workgroup was convened made up of diverse stakeholders including clients, family members, community members and contracted service providers. The workgroup met monthly with the goal of co-designing an MHSA 3- Year Plan Community Program Planning (CPP) process that is equitable, inclusive and honors and centers the voices of marginalized communities. The objectives of each meeting included the following:

1. Needs Assessment - review and advise on data needed to support a comprehensive needs assessment
2. Strategy Development- advise on the community input process and community engagement best practices, to ensure it is inclusive of all vulnerable communities
3. Strategy Development - support opportunities for all San Mateo County community members to provide input

MHSA Three-Year Plan Workgroup Members (13 were selected, 10 attended regularly)

Participant	Organization and/or Affiliations	Stakeholder Group
Adriana Furuzawa	Felton Institute	
Jean Perry	Behavioral Health Commission, LEEW, NAMI, League of Women Voters CA	Families of clients/consumers
Jessica Ho	North East Medical Services	Healthcare; Provider of behavioral health services; Provider of social services
Mary Bier	Daly City Youth Health Center, North County Outreach Collaborative, Mayor's Mental Health Initiative	Provider of behavioral health services; Provider of social services
Melissa Platte	Mental Health Association	Provider of behavioral health services
Michael Lim	Behavioral Health Commission, LEEW, CalVoices	Client/consumer of behavioral services; Families of clients/consumers
Pat Willard		Families of clients/consumers of behavioral health services
Sam Aval		Client/consumer of behavioral health services
ShaRon Heath	Voices of Recovery San Mateo County	Provider of behavioral health use services
William Elting	LEEW, Advocacy Academy, StarVista Crisis Center, Seeing Through Stigma, One New Heartbeat	Client/consumer of behavioral health services

The MHSA Three-Year Plan Workgroup was facilitated Doris Estremera, MHSA Manager and independent consultant, Tania Perez. See Appendix 2 for all MHSA Three-Year Plan Workgroup materials. The Workgroup guided and informed the process each step of the way:

1. Needs Assessment
    - Informed Data Collection resources
    - Advised on the Community Survey structure
2. Strategy Development
    - Informed Community Input Sessions strategy
    - Advised on the creation of a Facilitator Training for stakeholders to support input sessions
    - Facilitated Community Input sessions
3. MHSA Three-Year Plan Development
    - Reviewed the Recommended Strategies for accuracy

COMMUNITY PROGRAM PLANNING PROCESS

1. Needs Assessment – this phase of the CPP process included the following two steps:
    - ✓ Data Review: The following local plans, assessments, evaluation reports, and data were reviewed to identify prominent mental health and substance use needs reported across service sectors and the community.
        - BHC Crisis Coordination Recommendations
        - BHRS Cultural Competence Plan
        - BHRS Grievances
        - BHRS Consumer Perception Survey
        - BHRS QI Performance Measures and Performance Improvement Projects (
        - California Children's Report Card 2022
        - California Health Interview Survey
        - California Healthy Kids Survey 2019
        - County Health, Public Health Policy and Planning Community Collaboration Process
        - DHCS Performance Dashboard - Mental Illness Diagnosis; Penetration Rates
        - Dignity Health 2022 Community Health Needs Assessment
        - Director's Update Snapshot - Nov 2022
        - First 5 Strategic Plan 2020-2025
        - Full Service Partnerships Outcomes - Findings from FY 20-21
        - MHSA Annual Update FY 22-23 (MHSA-funded program reports)
        - 2022-23 Pride Center: COVID Impact Report

- San Mateo County Aging and Adult Services Area Plan
- San Mateo County All Together Better Indicators
- San Mateo County Health Alert Highlights
- San Mateo County Suicide Prevention Roadmap
- San Mateo County Veterans' Commission Strategic Plan 2019-2022
- Solutions for Supportive Homes - NAMI Family Survey
- Stigma Baseline Survey
- Strategic Plan on Homelessness
- Supporting At-Risk Youth, San Mateo County Local Action Plan 2020–2025 Juvenile Justice Coordinating Council (JJCC)
- The Health, Mental Health, and Social Service Needs of Asian Americans and Pacific Islanders in California
- Uncovering Unique Challenges: Variation in Unmet Mental Health Needs Among Latinx Ethnic Groups in California
- Use of Acute Mental Health Care in U.S. Children's Hospitals Before and After Statewide COVID-19 School Closure Orders
- "We Need Health for All": Mental Health and Barriers to Care among Latinxs in California and Connecticut
- Whole Person Care Annual Report 2021

All of the concerns identified in the needs assessment review were categorized into the following 8 areas of need.

i. **Access to Services** - this category captures the needs of diverse cultures and identities (race/ethnicity, LGBTQIA+, veteran status, age) related to accessing mental health and substance use services, including knowledge and education and culturally responsive approaches to engaging communities.

ii. **Behavioral Health Workforce** - this category captures the needs related to recruiting, developing, supporting and maintaining a sufficient workforce to address the needs and the diversity of the community. This includes supporting individuals with lived experience as clients and/or family members of clients of mental health and substance use services to join the workforce and support all services and programming.

iii. **Crisis Continuum** - this category captures needs related to mental health and substance use crisis response, as well as appropriate community-based supports and stabilization during and after a crisis.

iv. **Housing Continuum** - this category captures the housing needs for individuals living with mental health challenges ranging from assisted living facilities to having access to permanent supportive housing, to early assessment of risk of homelessness and culturally responsive approaches and support with locating and maintaining housing.

v. **Substance Use Challenges** - this category captures the increasing need for substance use services and supports that are accessible, integrated and coordinated with mental health services.

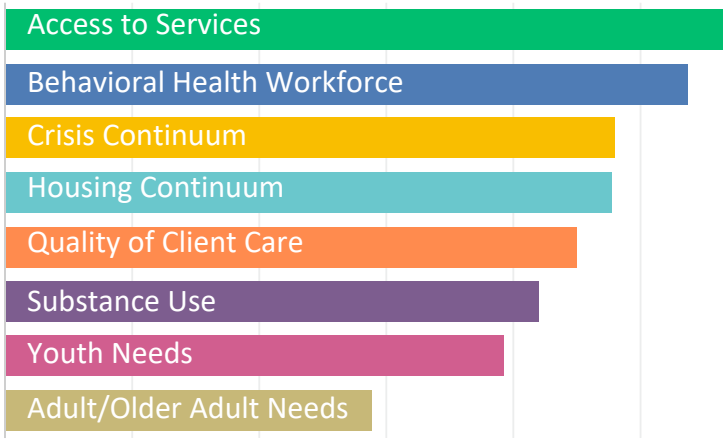
vi. **Quality of Client Care** - this category captures the needs of clients that are in treatment for mental health and/or substance use challenges to have timely access to care when needed, are successfully connected to services after an emergency and receive culturally responsive approaches to their treatment.

vii. **Youth Needs** - this category is age-based and captures mental health and substance use challenges for school to transition-age youth ages 6-25, it includes recent data for adolescent suicides, juvenile justice involvement, school-based and on-campus supports.

viii. **Adult/Older Adult Needs** - this category is age-based and captures mental health and substance use challenges for adults and older adults, it includes recent data related to increasing complexity of needs, general poor mental health outcomes, and suicide prevention needs.

✓ Community Survey: The identified needs from the review of local plans and data were included in an online survey that was distributed broadly to individuals living or working in San Mateo County. The survey asked respondents to share any additional concerns related to mental health and/or substance. Additionally, the survey requested that respondents rank the 8 areas of need in order of importance:

Community Survey – Areas of Need Prioritization:



There were 129 survey respondents to the survey, the Needs Assessment summary of results were presented to the MHSA Steering Committee on February 2, 2023, to launch the Strategy Development phase.

2. Strategy Development – this phase of the CPP process included the following two steps:

✓ Community Input: 31 community input sessions and key interviews with diverse groups and vulnerable populations (immigrant families, veterans and transition-age youth) were conducted. Based on advice from the MHSA Three-Year Plan Workgroup, groups were asked to select 1 of the 8 areas of need to brainstorm strategies in the areas of prevention, direct service and workforce supports. Previously, the survey was used to support the prioritization See Appendix 3 for the Community Input Session materials and input received. Participants were asked what possible solutions (services, programs, infrastructure, etc.) would they recommend to address the need they selected.

Area of Need	# Of Community Input Sessions
Access to Services	7
Behavioral Health Workforce*	9
Crisis Continuum	2
Housing Continuum	7
Substance Use Challenges	2
Quality of Client Care	2
Older Adult Needs	2
Youth Needs	9

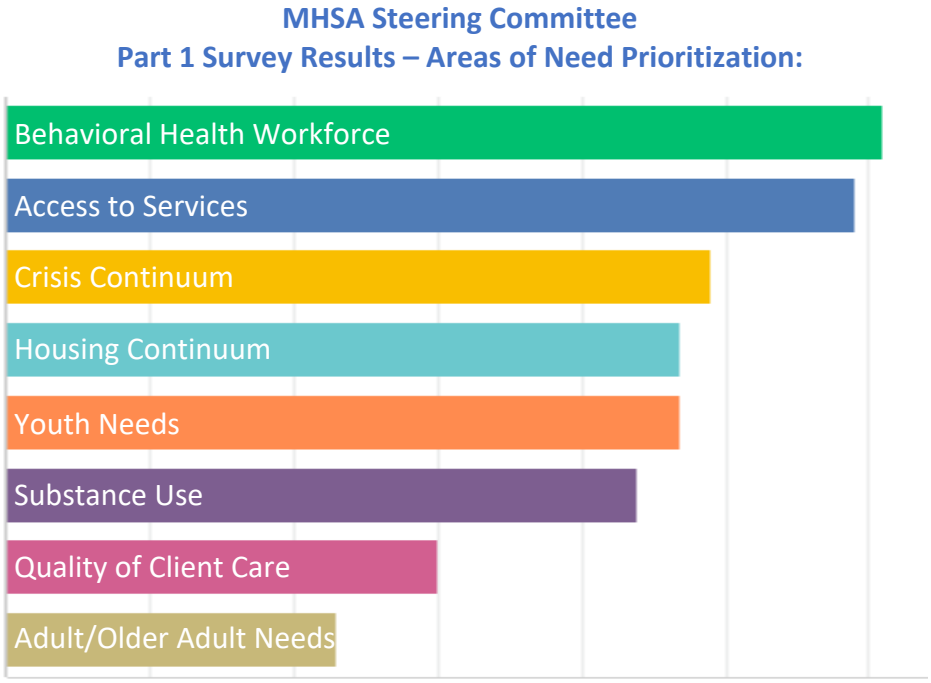
** As part of a simultaneous process to develop the MHSA 3-Year Workforce Education and Training (WET) Plan, 5 additional sessions were conducted to brainstorm around Behavioral Health Workforce strategies with the Diversity and Equity Council, Lived Experience and Education Workgroup, Alcohol and Other Drugs' Contracted Providers and BHRS Adult and Youth Leadership Teams.*

✓ Prioritization: To support the prioritization of strategies, participants were also asked: If you had to select one strategy to focus on over the next 3 years, which would you prioritize? Qualitative data analysis of all input received was conducted to identify the top strategy recommendations and key themes to present to the MHSA Steering Committee on May 4, 2023. Over 1,000 strategy ideas were shared via the Community Input sessions. This was narrowed down to 70 Strategy Recommendations across the 8 areas of need; strategies were included in this list if they were the top prioritized strategy by an input session group, they were

repeated across input sessions, and for the areas of need that weren't selected as often by community groups (i.e., crisis continuum, substance use challenges, quality of client care and adult/older adult needs) all strategies that received a prioritization vote during in the input sessions were included.

Additionally, three key themes emerged from the input sessions overall, these strategies were brought up in virtually all input session: 1) Increase community awareness and education about behavioral health topics, resources and services; 2) Embed peer and family supports into all behavioral health services; 3) Implement culturally responsive approaches that are data-driven to address existing inequities. The idea is to incorporate these components into EVERY prioritized strategy moving forward.

The key themes and 70 Strategy Recommendations were presented to the MHSA Steering Committee on May 4th along with pre-recorded stakeholder video testimonials for each of the 8 areas of need and with an opportunity for additional public comments from meeting participants. See Appendix 4 for the Strategy Recommendations and the summary of the MHSA Steering Committee prioritization. Following the meeting the MHSA Steering Committee members were asked, via an online survey, to rank the 8 areas of need and help narrow down the scope of MHSA resources (both funding and planning) over the next three years.



Given this prioritization, the areas of focus for the next three years will include Behavioral Health Workforce, Access to Services and addressing gaps in the Crisis Continuum. The MHSA Steering Committee was then asked in a follow-up survey to select their top Strategy Recommendations for each of the three areas of focus. The following include the strategies that received the majority of votes within each area of focus:

MHSA Steering Committee
Part 2 Survey Results – Strategy Recommendation Prioritization:

Behavioral Health Workforce

- Implement recruitment and retention financial incentives such as retention bonuses, signing bonuses, educational loanrepayment for staff and contracted providers.
- Provide support, retention and leadership development of peer and family support workers (training, fair compensation,career ladders, flexible hours, and mentorship).
- Implement supports for direct service staff, including peers, to advance in their careers, specifically BIPOC staff (e.g.,scholarships to pursue licensure/credentials, mentorship).

Access to Services

- Expand drop-in behavioral health services that includes access to wrap around services for youth.
- Coordinate behavioral health services for cultural and ethnic communities (centralize services, outreach and educationfor the Chinese community, hire bilingual/bicultural peer staff, etc.).

Crisis Continuum

- Expand non-armed 24/7 mobile mental health crisis response to serve the entire community.

3. MHSA Three-Year Plan – this phase of the CPP process includes the development of the plan, the 30-day public comment period and public hearing hosted by the Behavioral Health Commission (BHC) and the subsequent approval by the Board of Supervisors.
   - ✓ 30-Day Public Comment: The BHC voted to open a 30-day public comment period on June 7, 2023 and held a Public Hearing on July 5, 2023. Please see Appendix 1 for the presentation materials to the BHC and all public comments received. *[To be updated after the closing of the 30-day public comment process]*
   - ✓ Board of Supervisor Approval: The BHC also voted to submit the MHSA Three-Year Plan to the Board of Supervisors for approval after the closing of the public comment period on July 7, 2023.

This MHSA Three-Year Plan includes new funding allocations for the prioritized strategy recommendations, proposed funding allocations for other areas of need and strategy ideas that were identified; if there is an opportunity to leverage other efforts, initiatives, and/or external funding.

The MHSA Three-Year Plan also builds on previous priorities. Funding and implementation for recommendations from the FY 20-21 Housing Taskforce and the Full Service Partnership (FSP) Workgroups will continue. See the Housing and FSP Workgroup Updates section of the Annual Update (page 39).

Additionally, The MHSA Three-Year Plan includes ongoing funding allocations for existing MHSA-funded programs. These programs are monitored, evaluated and adjusted as needed during the MHSA Three-Year Plan implementation years and recommendations are made annually about continuing, adjusting and/or ending a program. Changes to existing programs and services are included in subsequent Annual Updates, which involve stakeholder input, the MHSA Steering Committee and the BHC 30-day public comment period. Agencies selected to provide MHSA-funded services go through a formal Request for Proposal (RFP) process to ensure an open and competitive process to funding opportunities. The RFPs are posted on the BHRS RFP website, www.smchealth.org/rfps, which includes a subscription option to receive notifications.

MHSA THREE-YEAR PLAN STAKEHOLDER INPUT

Extensive outreach was conducted to promote the MHSA Three-Year Plan Workgroup participation opportunity, the Facilitator Training opportunity, the MHSA Steering Committee meetings, and the Community Input sessions. Flyers were made available in English, Spanish, and Chinese. Stipends to consumers/clients and their family members and language interpretation were offered at every meeting, childcare for families and refreshments were offered for in-person meetings.

Input included perspectives from clients and family members, communities across geographical, ethnic, cultural and social economic status, providers of behavioral health care services, social services and other sectors. The sessions were conducted through 14 existing collaboratives/initiatives, 11 committees/workgroups, 3 geographically-focused collaboratives (Coastside, East Palo Alto and North County) and 3 stakeholder group key interviews of transition-age youth, immigrant families and veterans. The majority of the meetings were conducted online. Over 400 individuals participated across the various means of providing input (surveys, input sessions, public comments).

Input Session conducted

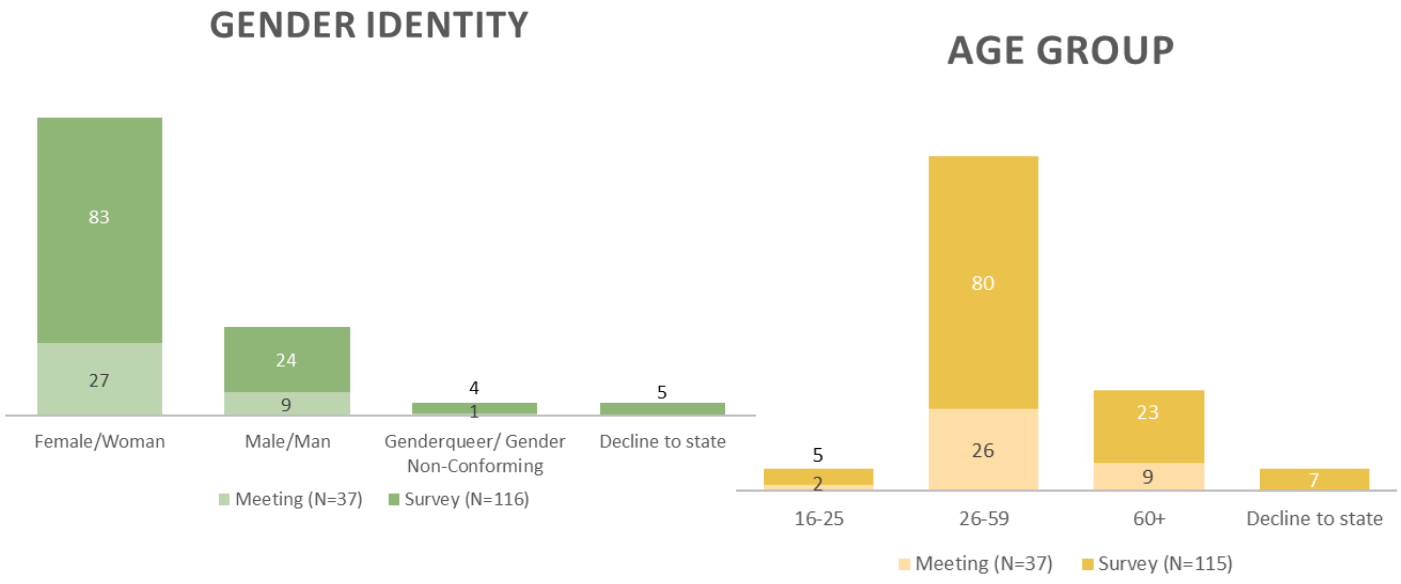
Date	Stakeholder Group	**Input Session Topics**
	MHSA Steering Committee	
2/2/23	4 Breakout Groups	Access to Services; Behavioral Health Workforce; Housing Continuum; Crisis Continuum
	Health Equity Initiatives	
2/3/23	Chinese Health Initiative	Access to Services
2/7/23	Pacific Islander Initiative	Youth Needs
2/8/23	Pride Initiative	Housing Continuum
2/14/23	African American Community Initiative	Quality of Client Care
2/14/23	Spirituality Initiative	Adult/Older Adult Needs
2/16/23	Native American and Indigenous Peoples Initiative	Quality of Client Care
2/16/23	Filipino Mental Health Initiative	Access to Services
2/28/23	Latino Collaborative	Access to Services
	Community Collaboratives	
2/10/23	North County Outreach Collaborative	Behavioral Health Workforce
2/16/23	East Palo Alto Behavioral Health Advisory	Behavioral Health Workforce
2/22/23	Coastside Collaborative	Access to Services
3/9/23	East Palo Alto Community Collaborative	Access to Services
	Peer Recovery Collaborative	
2/6/23	California Clubhouse/Heart & Soul	Housing Continuum
2/7/23	Voices of Recovery	Substance Use Challenges
	Behavioral Health Commission (BHC)	
2/1/23	BHC Older Adult Committee	Adult/Older Adult Needs

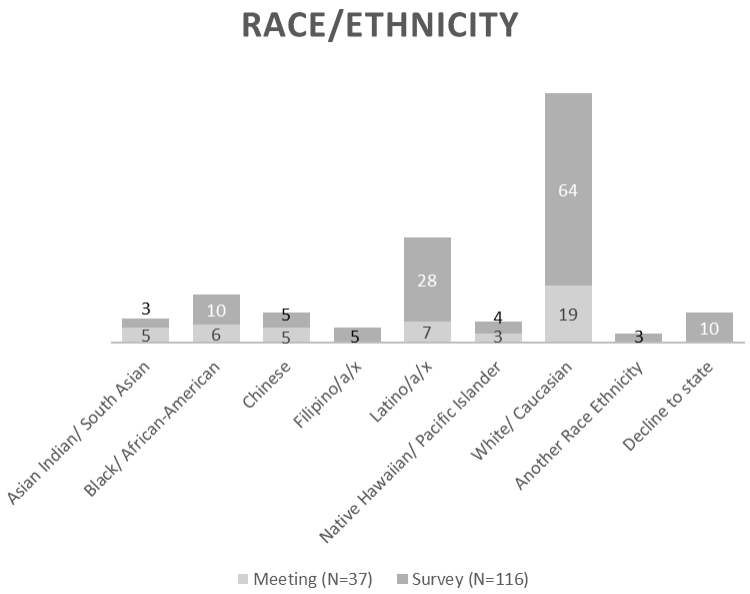
2/15/23	BHC Child and Youth Committee (3 Breakout Groups)	Youth Needs
2/15/23	BHC Adult Committee	Housing Continuum
2/21/23	BHC Alcohol and Other Drugs Committee	Substance Use Challenges
	Other Committees/Groups	
2/9/23	Housing Operations Committee	Housing Continuum
2/7/23	Lived Experience Education Workgroup	Housing Continuum
2/16/23	Contractors Association	Behavioral Health Workforce
2/20/23	Solutions for Supportive Housing	Housing Continuum
2/24/23	School Wellness Counselors	Youth Needs
2/14/23	BHRS Youth Leadership	Crisis Continuum
	Workforce Education & Training 3-Year Plan	
3/3/23	Diversity and Equity Council	Behavioral Health Workforce
3/2/23	Alcohol and Other Drug Providers	Behavioral Health Workforce
3/8/23	BHRS Adult Leadership	Behavioral Health Workforce
2/28/23	BHRS Youth Leadership	Behavioral Health Workforce
3/7/23	Lived Experience Education Workgroup	Behavioral Health Workforce
Key interviews conducted:		
Immigrant Families, Transition Age Youth, Veterans		Youth Needs; Access to Services

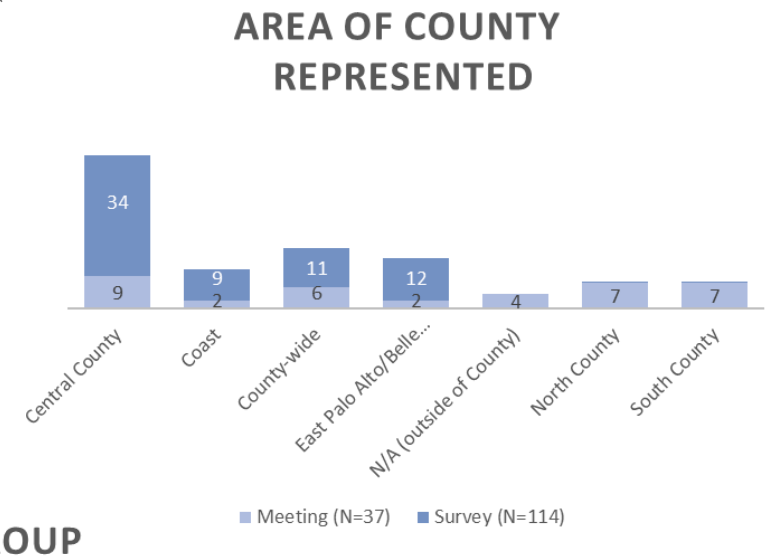
Demographics of participants

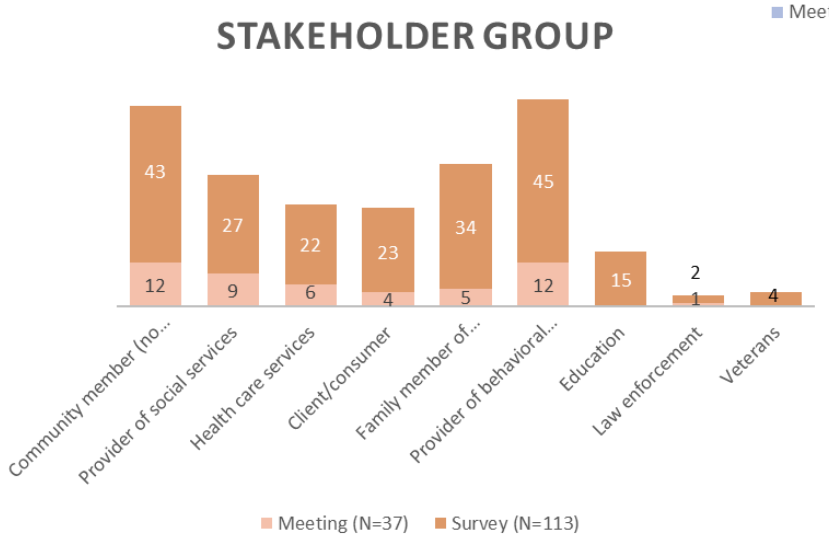
Demographic data was not collected from all 31 Community Input Sessions. 35 client and family members received stipends for participating in these sessions.

Demographics were collected for 129 survey respondents and 37 participants via a Zoom Poll feature during the two MHSA Steering Committee meetings focused on the MHSA Three-Year Plan Community Program Planning process.




RACE/ETHNICITY
3
5
10
6
5
5
5
28
7
4
3
64
19
3
10
Asian Indian/ South Asian
Black/ African-American
Chinese
Filipino/a/x
Latino/a/x
Native Hawaiian/ Pacific Islander
White/ Caucasian
Another Race Ethnicity
Decline to state
Meeting (N=37)
Survey (N=116)


AREA OF COUNTY REPRESENTED
34
9
9
2
11
6
12
2
4
7
7
Central County
Coast
County-wide
East Palo Alto/Belle...
N/A (outside of County)
North County
South County
Meeting (N=37)
Survey (N=114)


STAKEHOLDER GROUP
43
12
27
9
22
6
23
4
34
5
45
12
15
2
1
4
Community member (no...
Provider of social services
Health care services
Client/consumer
Family member of...
Provider of behavioral...
Education
Law enforcement
Veterans
Meeting (N=37)
Survey (N=113)

FISCAL SUMMARY

FISCAL SUMMARY

This Fiscal Summary section includes MHSA funding requirements and locally-developed guiding principles, history of revenues and expenditures, available unspent funds, reserve amounts, reversion projections and new funding allocations and ongoing priorities. See Appendix 5 for the FY 2022-23 Funding Summary by component.

MHSA FUNDING REQUIREMENTS

MHSA funded programs and activities are grouped into "Components" each one with its own set of guidelines and rules:

Component	Categories	Funding Allocation	Reversion Period
Community Services and Supports (CSS)	Full Service Partnerships (FSP) General Systems Development (GSD) Outreach and Engagement (O&E)	76% (51% of CSS must be allocated to FSP)	3 years
Prevention and Early Intervention (PEI)	Early Intervention Prevention Recognition of Signs of Mental Illness Stigma and Discrimination Access and Linkages	19% (51% of PEI must be allocated to program serving ages 0-25)	3 years
Innovations (INN)		5%	3 years

Additionally, Counties received one-time allocations in three additional Components, listed in the table below. Locally, ongoing annual and one-time allocations are prioritized to sustain the work in these components, as per the following guidelines:

- Up to 20% of the average 5-year MHSA revenue from the CSS Component can be allocated to WET, CFTN and Prudent Reserve.
- A maximum of 33% of the average Community Services and Supports (CSS) revenue received in the preceding five years maximum of 33% may fund the Prudent Reserve.
- Up to 5% of total annual revenue may be spent on administration and community planning processes.

Component	Amount Received	Reversion Period
Workforce Education and Training (WET)	$3,437,600 FY 2006-07 and 2007-08	10 years (expended)
Capital Facilities and Technology Needs (CFTN)	$7,302,687 FY 2007-08	10 years(expended)
Housing	$6,762,000 FY 2007-08	10 years (expended)
	Unencumbered FY 2015-16	3 years (expended)

MHSA FUNDING PRINCIPLES

MHSA Funding Principles build from the County's and Health division budget balancing principles to guide MHSA reduction and allocation decisions when needed. MHSA funding is allocated based on the most current MHSA Three-Year Plan and subsequent Annual Updates. Any funding priorities being considered outside of the MHSA Three-Year Plan priorities require MHSA Steering Committee approval and stakeholder engagement, which will include a 30-day public comment period and public hearing as required by the MHSA legislation.

The MHSA Funding Principles were presented to the MHSA Steering Committee in September 2018 for input and comment given a budget reduction planning throughout the County that was expected to have implications for MHSA funding. The Funding Principles will continue to lead budget decisions moving into COVID-19 pandemic anticipated recession.

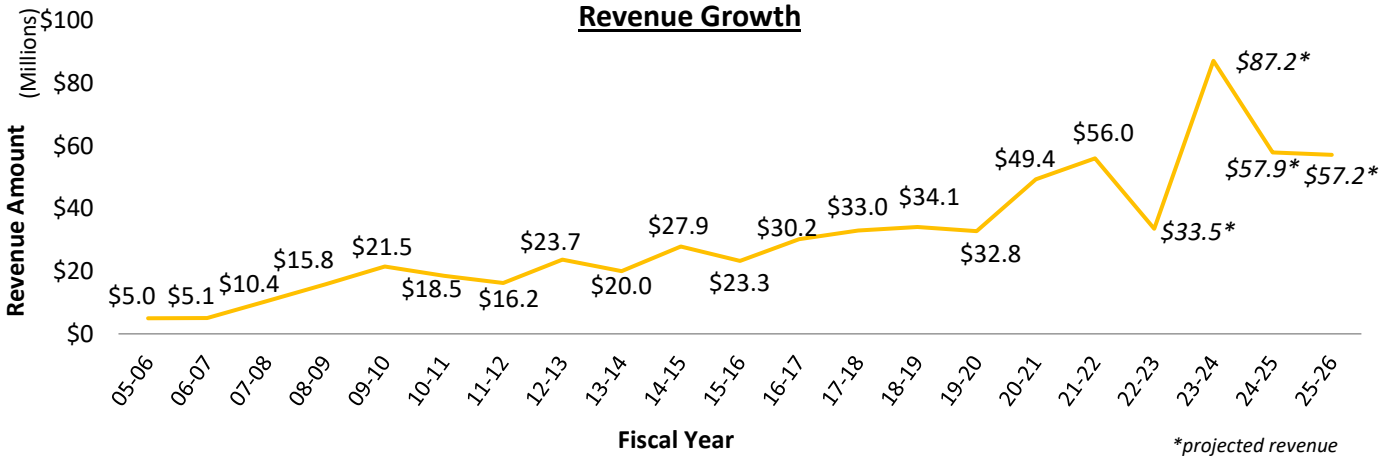
- *Maintain MHSA required funding allocations*
- *Sustain and strengthen existing MHSA programs* - MHSA revenue should be prioritized to fully fund core services that fulfill the goals of MHSA and prevent any local or realignment dollars filling where MHSA should.
- *Maximize revenue sources* - billing and fiscal practices to draw down every possible dollar from other revenue sources (e.g., Medi-Cal) should be improved as relevant for MHSA funded programs.
- *Utilize MHSA reserves over multi-year period* - MHSA reserves should be used strategically to mitigate impact to services and planned expansions during budget reductions.
- *Prioritize direct services to clients* - indirect services are activities not directly related to client care (e.g., program evaluation, general administration, staff training). Direct services will be prioritized as necessary to strengthen services to clients and mitigate impact during budget reductions.
- *Sustain geographic, cultural, ethnic, and/or linguistic equity* - MHSA aims to reduce disparities and fill gaps in services; reductions in budget should not impact any community group disproportionately.
- *Prioritize prevention efforts* - at minimum, 19% allocation to Prevention and Early Intervention (PEI) should be maintained and additionally the impact across the spectrum of PEI services and services that address the root causes of behavioral health issues in communities should be prioritized.
- *Evaluate potential reduction or allocation scenarios* – All funding decisions should be assessed against BHRS's Mission, Vision and Values and when relevant against County and Health System Budget Balancing Principles.

ANNUAL REVENUE GROWTH

Statewide, MHSA represents a little under a third of community mental health funding. In San Mateo County, MHSA represents about 15% of BHRS revenue. The five-year average annual revenue for San Mateo County, through FY 2021-22, totaled $39.2 million.

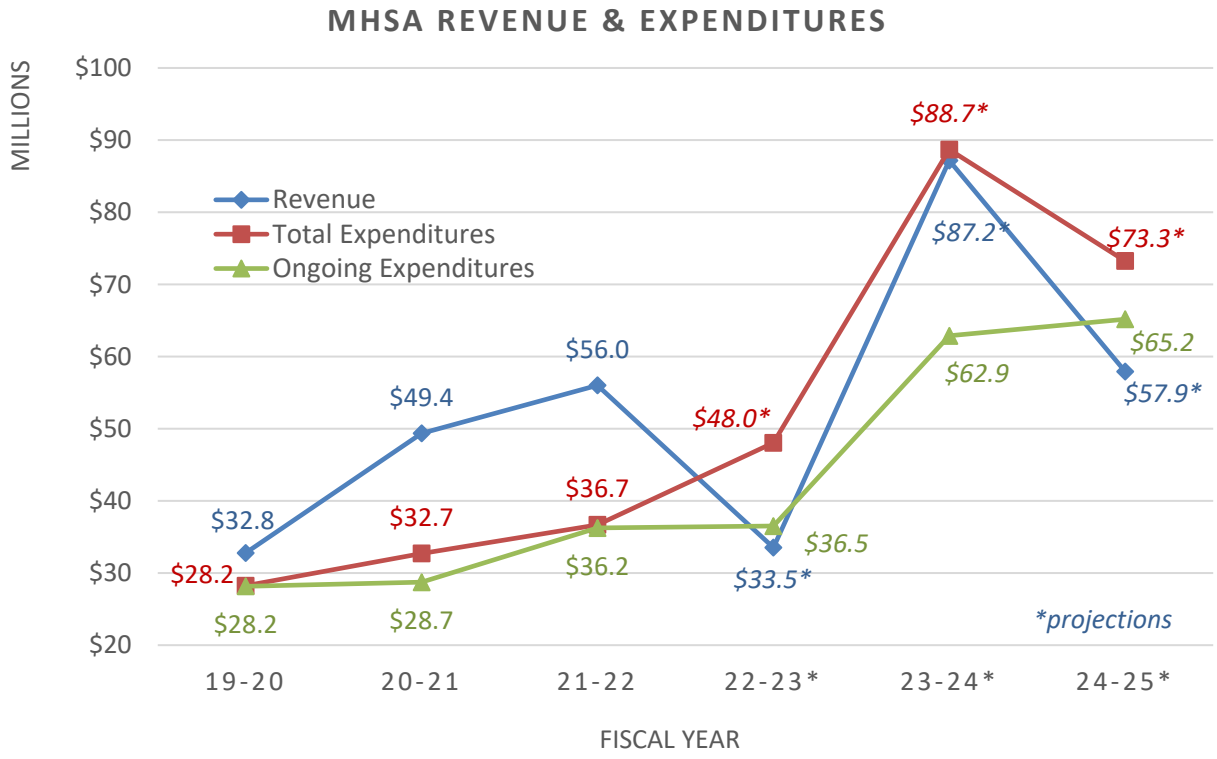
Annual MHSA revenue distributions are difficult to estimate and volatile. MHSA funding is based on various projections that consider information produced by the State Department of Finance, analyses provided by the California Behavioral Health Director's Association (CBHDA), and ongoing internal analyses of the State's fiscal situation. The following chart shows annual revenue allocation for San Mateo County since inception. Below are factors that impacted the decreases and increases in revenues throughout the years:

- FY 2005-06 and FY 2006-07: Community Services and Supports (CSS) funding only.
- FY 2007-08 and FY 2008-09: Prevention and Early Intervention (PEI) and Innovations (INN) funding were released in those years, respectively.
- FY 2010-11 and FY 2011-12: the California recession of 2009 led to decreased revenues
- FY 2012-13: Counties began receiving monthly MHSA allocations based on actual accrual of tax revenue (AB100), resulting in a "one time" allocation.
- FY 2014-15: changes in the tax law that took effect on January 1, 2013, led to many taxpayers filing in December 2012 resulting in a "one time" increase.
- FY 2019-20: "No Place Like Home" estimated cost for San Mateo County is $1.3 million, taken from revenue growth or "off the top." Additionally, there was an extension of filing of taxes to July 2020, due to COVID-19 pandemic.
- FY 2020-21 to 2021-22: unanticipated revenue increases due to 2020 delayed tax filing and COVID-19 pandemic.
- FY 2023-24: increases due to delayed tax filings and an unprecedented one-time adjustment of actual revenues received from taxpayers during the COVID-19 pandemic.



FISCAL CONSIDERATIONS

The following MHSA Revenue and Expenditure chart depicts MHSA Revenue in blue, Total Expenditures (including one-time allocations) in red, and Ongoing Expenditures in green per Fiscal Year (FY). Ideally, the Revenue and Ongoing Expenditures lines are as close as possible, which would mean that the majority of revenues received are being expended. Yet, as is depicted, this has not been the case starting in FY 2020-21. In FY 2019-20, at the start of the COVID pandemic, the State projected a recession so, Counties immediately shifted their three-year planning to either include reductions in programming or keep their budget status quo for FY 2020-21, as was the case in San Mateo. There was a slight increase in Total Expenditures (in red) due to previously approved one-time spend plans being implemented.



As soon as projections shifted to actual increases in millionaire's tax revenue, an MHSA Housing Taskforce was convened in San Mateo County to make recommendations for increased expenditures. Addressing the Housing Continuum for individual living with mental health challenges was the top priority for the previously submitted MHSA 3-Year Plan, FY 2020-21 through FY 2022-23. The MHSA Housing Taskforce recommendations included $10M in one-time funding to develop housing units for BHRS clients and $2.5M for ongoing housing related programming. Given start-up of projects, the majority of these funds are being spent down this current FY 2022-23 and will continue through FY 2023-24.

ONGOING OVER-REVENUE BUDGET STRATEGY

Previously, San Mateo County's MHSA ongoing budget amount would target the 5-year average revenue. This strategy helped maintain sufficient expenditures to avoid reversion and not overcommit to the volatile revenue projections. Starting FY 2021-22, the strategy shifted from targeting the 5-year average revenue to planning for **over-revenue** budgeting given the unanticipated high revenue received the year prior and projected ongoing increases. The actual expenditures did not end up over-revenue as planned given start-up delays in new programs and continued revenues increases significantly above the original projections at the time the budget was set. What this has meant for San Mateo County is growing unspent funds.

The ongoing budget planning for this MHSA Three-Year Plan will continue to target an amount above the five-year average, which is *estimated at $41.2M* through the current FY 2022-23. The proposed ongoing budget for FY 2023-24 is at $62.9M. While this is $20M+ over the typical target, the projected revenue jumps to $87.2M due to delay tax filings and adjustments for actual tax revenue received in 2021. This is an anomaly, in FY 2024-25 and 2025-26 the budget will be closer to $5-10M over the typical target. What this means is that the ongoing budget will be expending unallocated funds, which is the goal.

ANNUAL UNSPENT

The following analysis of funding availability for one-time spending and a proposed framework to focus the one-time spending on "big-ticket" items within these four identified categories: 1) Housing Projects; 2) Capital Facilities Projects; 3) Technology Needs; and 4) System Transformation; was introduced to the MHSA Steering Committee on February 2, 2023. The proposed One-Time Spend Plan was presented to the MHSA Steering Committee for input on May 4, 2023.

Fiscal Year End	*22/23*	*23/24*	*24/25*
Projected Revenue	$33,489,616	$86,773,003	$57,160,582
Ongoing Budget Expenditures	*$35,262,663*	*$62,454,373*	*$62,454,373*
One-Time Plan Expenditures	*$11,539,000*	*$24,075,316*	*$8,075,316*
Trust Fund Balance	*$68,795,845*	*$69,039,158*	*$55,670,051*
Obligated Funds:	**$41,934,594**	**$39,839,876**	**$39,974,767**
Reserve	$28,362,318	$28,362,318	$28,362,318
5% Innovation (INN)	*$1,674,481*	*$4,338,650*	*$2,858,029*
INN Ongoing	*$7,835,795*	*$6,733,908*	*$8,349,420*
WET/CFTN Encumbered	*$3,979,496*	*$400,000*	*$400,000*
Housing Funds	*$82,504*	*$5,000*	*$5,000*
Available One-Time	*$26,861,251*	*$29,199,282*	*$15,695,284*

ONE-TIME SPEND PLAN STRATEGY

Starting FY 2019-20, one-time spend plans were implemented as a strategy to reduce MHSA unspent funds. The previous FY 2022-23 MHSA Annual Update provided status updates for two separate One-Time Spend Plans; 1) a $6.9 million One-Time Spend Plan; and 2) an $11.7 million One-Time Spend Plan that was developed with stakeholders as part of a Housing Taskforce and post-COVID pandemic support needs. These plans were to be implemented through FY 2022-23 and will not be rolling over, unless specified in the new proposed One-time Spend Plan for FY 2023-24 through FY 2025-26. It was challenging to track and support the implementation of many small one-time projects especially with a growing amount of unspent. Therefore, the idea was proposed to focus on "big-ticket" items within these four identified categories: 1) Housing Projects; 2) Capital Facilities Projects; 3) Technology Needs; and 4) System Transformation.

The following proposed One-Time Spend Plan was developed through input received during the MHSA Three-Year Plan Community Input sessions and with the BHRS Management team to help identify system-wide projects in progress where there may be opportunity to leverage planning efforts and/or other funding, for example:

- Behavioral Health Continuum Infrastructure Grant (BHCIG): these projects often require **match funds** to construct, acquire, and/or rehabilitate capital facility assets or to expand mobile crisis infrastructure.
- Care Mobile Units (CCMU) state planning grant obtained significant local stakeholder input on mobile crisis care response in San Mateo. A local CCMU Action Plan is being developed that includes expansion of clinician-led non-armed crisis response to adults. The CCMU effort along with the BHCIG project to develop a Youth Crisis Stabilization and Youth Crisis Residential have led to a need to identify a **consultant** to assess data and help determine the current and future demand for these types of facilities or a combined effort where crisis stabilization and crisis residential are in adjacent facilities.

The proposed One-Time Spend Plan was presented to the Behavioral Health Commission (BHC) on June 7, 2023, along with the MHSA Three-Year Plan. Please see Appendix 1 for the presentation materials to the BHC and all public comments received. *[To be updated after the closing of the 30-day public comment process].*

Priority	Item	FY 23/24	FY 24/25	FY 25-26	TOTAL	Description
Housing	Hotel/Property Acquisition	$11,000,000			$11,000,000	To purchase hotels/properties for transitional and/or supportive housing.
	Supportive Housing Units	$5,000,000			$5,000,000	Rollover from previous one-time spend plan. ~25 supportive housing units for BHRS clients in Department of Housing (DoH) Affordable Housing Fund developments; Notification of Funding Availability (NOFA) released July 2022.
	Board and Care Buyout			$1,800,000	$1,800,000	Behavioral Health Continuum Infrastructure Grant - 10% match required.
Capital Facilities	Clinic Renovations	$4,000,000	$2,000,000	$2,000,000	$8,000,000	Renovations focused on improving safety at BHRS clinical sites and creating spaces that are welcoming for clients.
	Methadone Clinic	$1,800,000			$1,800,000	Behavioral Health Continuum Infrastructure Grant - 10% match required. On Veterans Administration campus in Menlo Park w/Santa Clara County.
	Youth Crisis Stabilization and Crisis Residential			$590,000	$590,000	Behavioral Health Continuum Infrastructure Grant - will update with a more accurate estimate - applying until round 6.
	2191-95 El Camino Real Property Renovations	$250,000			$250,000	Newly purchased property to be used by California Clubhouse and Voices of Recovery renovation and security enhancements.
Technology Needs	Asset Refresh	$260,000	$400,000	$540,000	$1,200,000	Computer/phone refresh and service coverage for BHRS.
System Transformation	Trauma Informed Consultants	$100,000	$100,000		$200,000	Estimated cost for consultant services for Trauma Informed and Employee Wellness supports.
	Youth Crisis Continuum of Care Consultant	$100,000	$100,000		$200,000	Estimated cost for consultant services to assist with BHRS System transformation around Youth Crisis Continuum of Care.
	Early Childhood, Children and Youth Collaborative	$555,000	$425,000		$980,000	Early Childhood Mental Health Network: training, capacity building, implementation, and expansion of trauma-informed services. San Mateo County Collaborative for Children and Youth: to design and implement a county-wide structure for children and youth behavioral health.

Priority	Item	FY 23/24	FY 24/25	FY 25-26	TOTAL	Description
System Transformation (cont'd)	Contractor Infrastructure	$2,500,000			$2,500,000	Infrastructure and training support for contracted providers to advance equity priorities and CalAIM payment reform.
	Communications	$375,000	$100,000	$100,000	$575,000	SMCHealth.org website update; BHRS third party services to allow for a more interactive and robust BHRS site + communication consultant to support series of BHRS and MHSA highlights and short 1-2 min videos.
	GRAND TOTALS	**$25,940,000**	**$3,125,000**	**$5,030,000**	**$34,095,000**	

TOTAL OPERATIONAL RESERVE

Counties are required to establish a Prudent Reserve to ensure the County programs will be able to serve clients should MHSA revenues drop. The California Department of Health Care Services (DHCS) Information Notice 19-017, released on March 20, 2019, established an MHSA Prudent Reserve level that does not exceed 33% of the average Community Services and Supports (CSS) revenue received in the preceding five years. For San Mateo County, this corresponds to $8,879,780, of which $ 4,755,145 was transferred to the Prudent Reserve in FY 2021-22 Annual Revenue and Expenditure Report (ARER). $600,000 was previously transferred in FY 2008-09.

Additionally, as per the FY 2019-20 MHSA Annual Update, the MHSA Steering Committee, the Behavioral Health Commission (local mental health board), and the Board of Supervisors, reviewed and approved a recommended Total Operational Reserve of 50% (Prudent Reserve + additional operating reserve), of the highest annual revenue for San Mateo County, which currently equals $28,362,318. The additional Operational Reserve is in a local MHSA Trust Fund unspent funds. This allows the flexibility in budgeting for short-term fluctuations in funding without having to go through the State's administrative process to access the Prudent Reserve, in the event that revenue decline is less than the State's threshold or funding is needed in a timely manner. Given the anomaly projected revenue increase in FY 2023-24, the recommendation is to keep the operational reserve at the $28,362,318 level.

REVERSION

MHSA legislation requires that MHSA funding under the key components (CSS, PEI and INN) be spent within 3-years, or it must be returned to the State for reallocation to other mental health agencies. San Mateo County's annual MHSA spending in CSS and PEI targets the 5-year average revenue. As long as the budgeted amount is expended, reversion is avoided.

INN on the other hand requires project approval by the Mental Health Services Oversight Accountability Commission (MHSOAC) before funds can be expended. Assembly Bill (AB) 114 established that the 3-year reversion time frame for INN funds commence upon approval of the project plans; this will minimize the reversion risk for funds accrued while planning for new projects and/or awaiting approval by the MHSOAC. AB 114 and Senate Bill (SB) 192 allowed Counties to submit a plan by January 1, 2019, for expending funds by June 30, 2020, that were deemed reverted as of July 1, 2017. San Mateo County submitted plans for INN in the amount of $3,832,545 and WET in the amount of $423,610. The INN plan was approved through September 22, 2022, the final expenditure reports are pending. The WET funding was expended as proposed.

At the wake of the COVID-19 pandemic, AB81 allowed for some flexibilities in MHSA regulations including reversion of FY 2019-20 funds. In San Mateo County, $922,534 were subject to reversion as of FY 2019-20. Since then, two new MHSA Innovation projects were approved and are planned for implementation. These projects encumbered the reverted funds. Therefore, San Mateo County will not be subject to return any INN funds to the State.

UNENCUMBERED HOUSING FUNDS

DHCS Information Notice 16-025 required Counties to complete *Ongoing Fund Release Authorization* for both existing and future unencumbered San Mateo County MHSA Housing Program funds (e.g., funds that are no longer required by a housing project, accrued interest, and/or other funds receive on behalf of the counties). Funds will be released annually to Counties. The *Ongoing Fund Release Authorization* was approved by the Board of Supervisors on April 7, 2020. San Mateo County received $105,039 in accrued interest and loan payments in September 2020 and $4,040 in July 2021.

The MHSA Housing Initiative Taskforce prioritized these funds to support ongoing "housing assistance" in the form of flexible funding for clients for housing related expenses (moving costs, deposits, first month rent). These unencumbered housing funds will be used to support the flexible fund.

SUMMARY OF THREE YEAR PLAN PRIORITIES

New fiscal priorities included in this Three-Year Plan:

- $34.1M One-Time Spend Plan through FY 2025-26
- $17.5M increase to the MHSA ongoing budget to a new total of $62.8M
    - $6.3M increases to Full Service Partnerships (FSP) including new CARE Courts FSP and FSP Housing supports.
    - $1.8 M increase to Workforce Education and Training including new Behavioral Health Workforce priorities
    - $1.8M increases to Prevention and Early Intervention including new Access to Services and Crisis Continuum priorities and substance use prevention expansions
    - $1.6M increases to Innovation for 5 new Innovation project approvals
    - $6M increases across ongoing programs for Cost of Living increases and permanent position conversions

NEW PRIORITY EXPANSIONS

Following are the allocations for the new priority expansions, as per the MHSA Three-Year Plan Community Program Planning process.

Area of Focus	Strategy	Allocation
Behavioral Health Workforce	Implement recruitment and retention financial incentives such as retention bonuses, signing bonuses, educational loan repayment for staff and contracted providers.	$300,000
	Provide support, retention and leadership development of peer and family support workers (training, fair compensation, career ladders, flexible hours, and mentorship).	$200,000
	Implement supports for direct service staff, including peers, to advance in their careers, specifically black, indigenous, people of color (e.g., scholarships to pursue licensure, mentorship).	$300,000
Access to Services	Expand drop-in behavioral health services that includes access to wrap around services for youth.	$500,000
	Coordinate behavioral health services for cultural and ethnic communities (centralize services, outreach and education for the Chinese community, hire bilingual/bicultural peer staff, etc.).	$200,000
Crisis Continuum	Expand non-armed 24/7 mobile mental health crisis response to serve the entire community.	$650,000

PREVIOUS PRIORITIES

MHSA priorities identified by stakeholders in the previous Three-Year Plan, that have not been implemented, remain top priorities moving forward.

FSP Workgroup recommendations
Between September-November 2021, a Full Service Partnership (FSP) Workgroup made up of diverse stakeholders including clients, family members, adult and children and youth FSP providers and County staff convened to provide input on FSP service requirements and outcomes that would support continuous improvement planning.

FSP Workgroup recommendations across 9 areas of FSP improvement were included in an updated Request for Proposal (RFP) process for both Child/Youth (released FY 2022-23) and Adult/Older Adult (targeted for FY 2023-24). To support the recommendation to "Enhance Ongoing Data Collection and Evaluation", the American Institutes for Research (AIR), an independent evaluation consultant, began conducting annual qualitative data collection, focus groups and key interviews, with clients, families and providers of FSP services. AIR analyzes FSP quantitative data for youth, transition age youth and adults to understand how enrollment in the FSP is promoting resiliency and improved health outcomes of clients living with a mental illness. Additionally, AIR participated in a statewide process to identify continuous improvement metrics and will be supporting ongoing continuous improvement data analysis.

Housing Taskforce Recommendations
Between March and May 2021, a Housing Taskforce made up of diverse stakeholders including clients, family members, service providers and County departments convened, to prioritize and make recommendation related to funding for housing resources and supports; a full spectrum of housing services for individuals living with mental health challenges was developed. The details of both these groups were reported in previous MHSA Annual Updates. The following table is intended to report on the progress of the 11 Housing Taskforce Recommendations.

	Housing Taskforce Recommendations (Listed in order of priority)	Progress	Notes
1.	Housing Funds for the Department of Housing development of Supportive Housing Units for clients within affordable housing	Completed	Year 1 – 25 MHSA units in East Palo Alto, North Fair Oaks and South San Francisco Year 2 – 25 MHSA units in Redwood City and Daly City
2.	Housing locator: a) Maintenance of a BHRS housing website with real-time availability; b) Linkages to BHRS case managers; c) Landlord engagement; d) Community mental health 101; and e) locators (mental health counselors) and peer navigators	In Progress	Request for Proposal process (items 2, 6, 7 combined) targeted for Fall 2023
3.	Supportive services for new housing units	Not Yet Started	Pending new housing units are developed and available to clients

4.	Mental health workers for Homeless Outreach	Completed	2 clinicians hired for Homeless Engagement Assessment and Linkage (HEAL) team
5.	Transitional housing supports to adequately serve SMI population, including special populations (e.g., transition-age youth, substance use, etc.)	Not Yet Started	Target TBD
6.	Outreach and field-based services to support long-term housing retention; a team of Occupational Therapist and Peer Counselor with co-occurring capacity to support independent skills development	In Progress	See item #2
7.	Development of an online BHRS housing webpage with comprehensive one-stop housing information (including data dashboard for unmet need)	In Progress	See item #2
8.	Flexible funds for housing related expenses (moving costs, deposits, first month rent)	Completed	Flex funds available starting FY 2022-23
9.	Increase FSP housing funds	Completed	Adult housing rates increased
10.	Incentives and supports for licensed Board and Cares to improve quality of services	Completed	Ongoing
11.	Increase FSP slots for children/youth and transition-age youth	Completed	10 Children/Youth and 5 TAY FSP slots

THREE-YEAR PROGRAM PLAN

THREE-YEAR PROGRAM PLAN FY 2023-2026

Welfare and Institutions Code Section (WIC) § 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan (Plan) that addresses each MHSA component and include expenditure projections. The San Mateo County MHSA Three-Year Plan aligns with the Behavioral Health and Recovery Services (BHRS) of the San Mateo County Health System's commitment a holistic view to the health and well-being of individuals, placing high value in care coordination, collaboration and integration, prevention and early intervention, data-driven interventions, cost control, quality improvement, and meaningful outcomes.

The following pages describe the MHSA Three-Year Plan programs for FY 2023-24 through FY 2025-26, which has been developed through comprehensive assessment and stakeholder input from previous years, new priorities identified through this year's Community Program Planning process, and the fiscal projections for the next three years. This multi-year approach facilitates stability, ensures a balanced approach when considering programmatic changes, and utilizes higher revenue years and unspent funds.

COMMUNITY SERVICE AND SUPPORTS (CSS)

CSS provides direct treatment and recovery services to individuals of all ages living with serious mental illness or emotional disturbance with a focus on un-served and underserved populations. CSS is the largest MHSA component, with an allocation of 76% of MHSA funding. There are three different service categories in CSS: Full Service Partnerships (FSP), General System Development (GSD), and Outreach and Engagement (O&E). At least 51% of CSS funds must be spent on FSPs and focus on un-served and underserved populations.

FULL SERVICE PARTNERSHIP (FSP)

FSPs include 24 hours a day, 7 days a week services; peer supports; high staff to client ratios for intensive behavioral health treatment including medications; linkage to housing; supported education and employment; treatment for co-occurring disorders; skills-based interventions, among others. The target population for FSPs include, high risk children and youth who would otherwise be placed in a group home; seriously mentally ill and dually diagnosed adults including those eligible for diversion from criminal justice incarceration; incarcerated individuals; persons placed in locked facilities who can succeed in the community with intensive supports; and individuals with frequent emergency room visits, hospitalizations, and homelessness; and seriously mentally ill older adults at risk of or currently institutionalized who could live in a community setting with intensive supports.

The following CSS FSP component categories will continue through FY 2025-26:

CHILDREN AND YOUTH FSP WRAPAROUND

Children and Youth FSP Wraparound programs help the highest risk children and youth with serious emotional disorders to achieve independence, stability, and wellness within the context of their cultures, communities, and family/caregiver units, and to remain living in their respective communities with their families or caregivers while attending school and reducing involvement in juvenile justice and child welfare. FSP Wraparound services will be based on clients' individual needs and goals, with a commitment to do "whatever it takes" to help them progress toward recovery, health, and well-being. Services are delivered by specialized multi-disciplinary FSP Wraparound Teams and obtain Wraparound certification from the California Department of Social Services (CDSS) and the Department of Health Care Services (DHCS).

Integrated FSPs are clinic-based FSP services for the Central and South Youth Clinic (outpatient), as well as intensive school-based services, Therapeutic Day School.

Comprehensive FSPs services are provided to children, youth and their families. Children and youth are primarily referred to the Integrated FSP program by Human Services Agency (child welfare), Juvenile Probation, San Mateo County Clinics, and schools (typically with an Individualized Education Program – IEP plan for emotional disturbance).

Out-of-County Foster Care FSP are for foster care youth temporarily outside of the County to support and stabilize youth in the foster home, support the foster family, and facilitate the return of the youth to San Mateo County, will also continue.

The Children and Youth FSP slots were increased by an additional 20 slots: 10 to Integrated SAYFE FSP and 5 to Comprehensive FSP and 5 to Out-of-County FSP settings.

Projected number of children and youth to be served through FSPs: 225

Program	*Cost per year**	*# Of slots*	*# Clients to be served*
Integrated "SAYFE" FSP	$933,481	35	95
Comprehensive "Turning Point" FSP	$2,518,639	45	120
Out-of-County Foster Care FSP	$180,802	10	10

**This is the MHSA contribution and is not representative of the full cost of providing services*

TRANSITIONAL AGE YOUTH (TAY) FSP

Comprehensive TAY FSPs provide intensive community based supports and services to youth identified as having the "highest needs" who are between the ages of 16-25. Specialized services to TAY with serious emotional disorders are provided to assist them to remain in or

return to their communities, support positive emancipation including transition from foster care and juvenile justice, secure, safe, and stable housing and achieve education and employment goals. TAY FSPs helps reduce involuntary hospitalizations, homelessness, involvement in the juvenile justice system and improves the quality of life for youth clients. *TAY Drop-in Centers* are community-based resource centers catering to young adults between the ages of 18-25 years. Drop-in site services are peer-led and serve as a safe and confidential space offering free resources, activities and workshops, and opportunities for socialization and peer connection. The Drop-in Centers provide regularly scheduled programming such as community outings, social activities, personal growth, and wellness workshops, as well as access to computers, the internet, a clothes closet, and food. Peer Partners lead activities to support development of necessary skills to successfully transition to adulthood. Peer Partners are trained in Youth Development, Harm Reduction, and peer counseling techniques. Peer Partners offer support and peer mentorship; give resources; and plan, implement, and co-facilitate groups and activities. Goals of the Drop-in Centers are:

- Promote socialization and community connectedness
- Support academic and/or vocational exploration and growth
- Encourage the development of independent living skills
- Empower rising leaders and advocates

TAY FSP Enhanced Supported Education services are provided to TAY with emotional and behavioral difficulties and/or substance use challenges. Outreach activities engage TAY in educational or vocational activities for educational plans and employment. Classes and groups also build on recovery principals such as WRAP (Wellness Recovery Action Plan), personal and career skills-building, resource education and linkage, empowerment through education and career development, leadership potential, having a peer support group, and engagement utilizing active listening, motivational interviewing, and supportive engagement.

Projected number of TAY to be served through FSPs: 250

Program	*Cost per year*	*# Of slots*	*# To be served*
Comprehensive "Turning Point" FSP + Drop-In Centers	$2,732,836	45	60 FSP + 100 Drop-in
Supported Education for TAY	$210,413	20	90

ADULT AND OLDER ADULT FSPS

Adult and Older Adult Comprehensive FSPs provide comprehensive, intensive community-based behavioral health services to the highest risk adults and highest risk older adults/medically fragile adults living with severe mental illness (SMI) in San Mateo County. FSP programs assist individuals to achieve independence, stability and wellness within the context of their cultures, and communities. Services are based on clients' individual needs and goals, with a commitment to do "whatever it takes" to help them progress toward recovery, health, and well-being.

The overall goal of the adult FSPs is to divert individuals living with SMI and/or substance use disorder (SUD) from the criminal justice system and/or acute and long-term institutional levels of care (locked facilities) so that they can succeed in the community with sufficient structure and support and support improvements in their quality of life. A housing program provides FSP clients stable housing by providing additional oversight and support to enable members who might otherwise be at risk of losing their housing to stay consistently housed. This also includes some supplementing of residential care facilities for clients who require this level of supervision and services.

FSP Teams will serve a combination of eligible SMI/SUD adults and older adults, Assisted Outpatient Treatment – AOT/Laura's Law eligible clients, and/or justice involved (AB109) clients. AOT serves individuals with serious mental illness who currently are not receiving treatment and may or may not require court intervention to receive treatment. AOT FSP services are based on the Assertive Community Treatment model (ACT) of care.

Integrated FSPs support the South County Adult Behavioral Health Outpatient and serves complex SMI adult client population. Due to the location of the clinic the program serves as the catchment area providing services to individuals from the women's and men's county jail, Redwood House crisis residential, Cordilleras Mental Health Rehabilitation Centers (MHRC), three inpatient SUD treatment programs, and two homeless shelters. The Integrated FSP program provide 50 hours of service per week for 3 different levels of intensity.

Community Assistance, Recovery and Empowerment (CARE) Courts FSP

CARE Court FSPs will support the implementation of a new legislative requirement, under SB 1338 CARE Act. The first cohort of counties to implement the CARE Act included Glenn, Orange, Riverside, San Diego, Stanislaus, Tuolumne, and San Francisco, which are working to launch October 2023. San Mateo County is expected to follow. Care Court FSP will work collaboratively with the Civic Court System to serve individuals deemed eligible, as they are at-risk of civic commitment/committed. Eligible individuals struggling with untreated SMI/SUD will receive a court-ordered Care Plan for up to 24 months. Each plan is managed by a care team in the community and can include clinically prescribed, individualized interventions with several supportive services, medication, and a housing supports. The client-centered approach also includes a public defender and supporter to help make self-directed care decisions in addition to their full clinical team. The court-ordered response can be initiated by family, county and community-based social services, behavioral health providers, or first responders.

Projected number of adults, older adults served through FSPs: 530

Program	*Cost per year**	*# Slots*	*# To be served*
Adult and Older Adult Comprehensive FSP	$6,169,750	375	
Integrated FSP	$150,535	20	
Care Courts FSP	$2,812,334	85	

**This is the MHSA contribution and is not representative of the full cost of providing services*

FSP FLEXIBLE FUNDS

Flexible funding "Flex Funds" are an integral component to supporting a "whatever it takes" philosophy of FSPs. Flex funds are for FSP clients, to provide essential supports not typically found on the menu of traditional behavioral health services and are used when other resources have been exhausted. They promote shared responsibility with the client, such as cost-sharing or a gradual decrease in funds contribution. Allowable Flex Fund expenses include: 1) housing supports – security deposits, credit reporting fees, background checks, utilities, moving expenses, furniture/appliances, hotel/shelter subsidies, rent/lease subsidies, residential substance use treatment, transitional residential expenses, etc.; and 2) client supports – auto expenses, clothing, alternative care, education expenses, employment expenses, food, hygiene items, medical/dental/optical care, social activities, transportation, etc.

All FSP programs will have access to an additional annual Flexible Funding pool of funds held by BHRS. The total Flexible Funding pool amount available to each provider will be calculated based on client slots assigned, at a rate of $3,000 per slot and can be used as needed per client served. This funding will be available for FSP Provider(s) to draw down as needed for additional support services.

Projected number of clients served: 585

Program	*Cost per year**	*# To be served*
FSP Flex Funds	$1,755,000	585

**This is the MHSA contribution and is not representative of the full cost of providing services*

HOUSING SUPPORTS

Housing supports can include various strategies including scattered site housing, augmented board and cares, room and boards, temporary shelter beds, transitional housing and permanent supportive housing, amongst other strategies. Additionally, a comprehensive continuum of services can include pre-housing engagement strategies such as drop-in centers, field services targeting the homeless, and linkages and peer support post-psychiatric emergency, hospitalization and incarceration.

FSP HOUSING

TAY FSP Housing Support Program provides housing subsidies and a small cluster of apartments for transition-age youth. The program locates and obtains housing units; ensures that leased housing remains in clean, safe, and habitable condition; collaborates regularly with FSP providers to ensure that TAY receive all practical chances and opportunities to remain housed (utilization of creative, harm reduction based techniques that go well beyond standard property

management practices and activities); and manages relationship with property owners including timely payment of rent, monitoring and enforcement of lease provisions, and problem solving in the event of disruptive behavior. Occupational therapists teach daily living skills, medication management, household safety/cleanliness, budgeting, and roommate negation skills are a part of the treatment and education of the youth.

Adult and Older Adult FSP Housing providers helps locate and obtain timely housing placements for FSP clients and manage housing property owner relationships to provide a variety of clean, safe and affordable stable supervised housing options for adult and older adult FSP clients. A strong continuum of housing options and care is necessary and required for FSP clients. The range of housing options provided by proposers should include emergency shelter, room and board, board and care, shared housing, and independent living. FSP housing and peer specialists provide direct client housing supports (e.g., housing navigation, application assistance, moving supports, and housing maintenance).

Adult and Older Adult Supported Housing Services are provided to Cedar Street Apartments (14 units, 5 MHSA units) and Waverly Place Apartments (15 units, all MHSA) 10 formerly chronically homeless adults living with serious mental illness and SUD are original tenants, having moved in when the project opened more than 4 years ago. All units are designated as MHSA units.

Projected number of clients served through housing supports: 247

Program	*Cost per year**	*# To be served*
TAY Supported Housing	$447,283	30
Adult and Older Adult FSP Housing	$4,505,321	188
Adult and Older Adult Supported Housing Services	$222,040	29

**This is the MHSA contribution and is not representative of the full cost of providing services*

AUGMENTED BOARD AND CARES

Augmented Board and Cares (B&Cs) provide a supported living environment for clients with severe mental illness (SMI) that have completed a social rehabilitation program or are stepping down from a locked setting. They are psychiatrically stable, compliant with medications and in need of a supported living environment. These placements are needed to afford SMI client's an opportunity to live in the community in a supported living environment. There is one BHRS staff that is the designated B&C Liaison. This staff approves B&C referrals, completes assessments, oversees admissions and discharges to BHRS contracted B&Cs.

The B&C provides three meals a day, medication management which includes storing and administration of medications. They regularly collaborate with the client's treatment team and conservator about client's progress, and/or issues that impact the client's placement.

Projected number of clients served: 100

Program	*Cost per year**	*# To be served*
Augmented Board and Cares	$3,142,969	100

**This is the MHSA contribution and is not representative of the full cost of providing services*

GENERAL SYSTEM DEVELOPMENT (GSD)

General Systems Development (GSD) in San Mateo County has been primarily focused on supportive services for individuals with mental illness through integration of peer and family partners throughout the behavioral health system of care, and community peer run and peer peer-focused wellness centers; system transformation strategies that support integration of services across various sectors impacting individuals with mental illness' lives including substance use, dual diagnosis intellectual disability, criminal justice, child welfare, aging; and integrating evidence-based practice clinicians throughout the system. Current programs under this component category will continue.

SUBSTANCE USE INTEGRATION

Substance use providers – nine substance use providers and BHRS staff to support integration of substance use and mental health services. Additionally, two clinical contractors provide co-occurring capacity development trainings to BHRS staff and multiple agencies, consultation for complex co-occurring clients and system transformation support for relevant programs.

Substance use residential for youth includes a collaborative contract for youth residential treatment beds and shared costs with other Bay Area counties based on utilization. *Substance use residential for adults* will provide trauma-informed residential withdrawal management (detox) services to safely treat those with opioid and other substance use disorders including licensure to provide Incidental Medical Services (IMS) – on-site medical monitoring from a health care practitioner versed in addiction medicine. Also includes funding to help with the housing costs of individuals in treatment who need sober living housing.

Recovery Support Services are peer-led education, wellness, advocacy, and support services for individuals in or in need of long-term recovery from alcohol and other drug addictions, equally sharing these opportunities and support services with impacted families.

The Cariño Project – Substance Use Services will integrate substance use case management and early intervention and treatment including individual and/or group evidence-based practices and psychoeducation for the Coastside region and through the Cariño Project.

Projected number of clients served: 5,580

Program	*Cost per year**	*# To be served*
Substance Use Providers	$742,955	300
Substance Use Residentials – Youth and Adults	$635,820	515**
Recovery Support Services	$245,047	500
The Cariño Project – Substance Use Services	$44,000	30

**This is the MHSA contribution and is not representative of the full cost of providing services*
*** Unique counts do not represent client readmission; it may take many re-attempts for a client in their recovery journey.*

OLDER ADULT SYSTEM OF CARE

Older adult system of care creates integrated services for older adults to assure that there are sufficient supports to maintain the older adult population in their homes and community, in optimal health and sustaining independence and family/community connections.

Older adult outreach creates integrated services for older adults to assure that there are sufficient supports to maintain the older adult population in their homes and community, in optimal health and sustaining independence and family/community connections.

Projected number of older adult clients served: 715

Program	*Cost per year**	*# To be served*
Older Adult System of Integrated Services (OASIS)	$877,195	175
Peer Counseling - Older Adult Outreach (50%)	$150,095	540

**This is the MHSA contribution and is not representative of the full cost of providing services.*

CRIMINAL JUSTICE INTEGRATION

Criminal justice integration programs provide treatment and support services to seriously mentally ill non-violent offenders and divert from incarceration into community-based services.

Projected number of mentally ill non-violent offender clients served: 85

Program	*Cost per year**	*# To be served*
Pathways Court Mental Health Program + Housing	$346,282	50
Criminal Justice Restoration and Diversion	$250,000	35

**This is the MHSA contribution and is not representative of the full cost of providing services*

OTHER SYSTEM DEVELOPMENT

Prenatal to Three Initiative (formerly Child Welfare program) supports parents and/or caregivers of children through age 5 as well as pregnant mothers and pregnant teens with mental health treatment and other social needs resources. Specifically, staff serve women eligible for Medi-Cal with serious mental illness (SMI) who require psychotherapy and medication management of their symptoms.

Dual diagnosis, developmental disabilities services support the special mental health needs of clients with developmental disabilities with comprehensive mental health treatment including medication management.

Trauma-Informed Interventions include the Neurosequential Model of Therapeutics (NMT) program within both the Youth and Adult System of Care; created to improve the well-being of clients who have experienced severe trauma. NMT-certified providers rely on assessments of clients' functional capacities in four domains—sensory integration, self-regulation, relational, and cognitive—to inform the selection of individualized therapeutic interventions.

Evidence-based practices (EBP) clinicians include staffing specialized in providing evidence-based services for youth and adult clients throughout the system. System transformation is supported through an ongoing training of evidence-based treatment practices that better engage consumers and family members as partners in treatment and contribute to improved consumer quality of life.

School-Based Mental Health (SBMH) program serves special education students suffering from serious mental illness (SMI) and connects them with appropriate behavioral health services that enable them to continue receiving classroom instruction.

Crisis management serves the Crisis, Outreach, and Engagement team at BHRS and four other programs: Assisted Outpatient Therapy (AOT), Psychiatric Emergency Response Team (PERT), Healthcare for the Homeless (HCH), and Homeless Engagement Assessment and Linkage (HEAL). The crisis manager's responsibilities include overseeing the program, and implementation to conduct crisis response services outreach and engagement for the public.

Projected number of clients served: 1,885

Program	*Cost per year**	*# to be served*
Prenatal to Three Initiative	$677,598	750
Puente Clinic – Dual Diagnosis	$457,736	270
Trauma-Informed Interventions (NMT Adults and Youth)	$883,838	70 adults;
Evidence-Based Practice (EBP) Clinicians	$1,824,235	450
School-based MH	$317,319	345
Crisis Management	$284,340	N/A

**This is the MHSA contribution and is not representative of the full cost of providing services*

PEER AND FAMILY PARTNER SUPPORTS

Peer and family partner supports assist with employment of individuals with lived experience as a client/consumer of behavioral health services and family partners with lived experience within the county behavioral health system of care, which recognizes the special contributions and perspectives of behavioral health clients and family members and encourages the valuable role of peer support and case management.

Client Stipends promote and fairly compensate participation of clients and family members in key Behavioral Health activities including Health Equity Initiatives, committees, consultations, and focus groups, and services such as participating on program review and hiring panels.

Wellness centers support wellness and recovery of clients and their families in the community. Provide opportunities for increased socialization, employment, education, resource sharing and self-advocacy.

Peer Support and self-help services for clients of behavioral health services in San Mateo County. Activities include special events/outings, community education, peer support and self-help groups, and advocacy skill development.

Supported Employment includes vocational rehabilitation for individuals living with serious mental illnesses that emphasizes helping obtain competitive work in the community and providing the supports necessary to ensure their success in the workplace.

Projected number of clients served through peer support strategies: 705

Program	*Cost per year**	*# To be served*
Peer Support Workers and Family Partners	$2,033,683	120
Client Stipends	$45,609	150
Barbara A. Mouton Multicultural Wellness Center	$220,956	100
California Clubhouse	$395,716	170
Peer Support	$ 850,124	120
Supported Employment	$200,000	45

**This is the MHSA contribution and is not representative of the full cost of providing services*

PRIMARY CARE INTEGRATION

Primary care-based efforts identify and engage individuals presenting for healthcare services that have significant needs for behavioral health services. Primary Care Interface focuses on identifying persons in need of behavioral health services in the primary care setting. BHRS clinicians are embedded in primary care clinics to facilitate referrals, perform assessments, and refer to appropriate behavioral health services if deemed necessary. Ravenswood provides

outreach and engagement services and identifies individuals presenting for healthcare services that have significant needs for behavioral health services.

Projected number of clients served: 1,590

Program	*Cost per year**	*# To be served*
Primary Care Interface (20% CSS; 80% PEI)	$196,782	1,040
Ravenswood Family Health Center (40% CSS; 60% PEI)	$18,082	550

**This is the MHSA contribution and is not representative of the full cost of providing services*

INFRASTRUCTURE STRATEGIES

Infrastructure- BHRS administration, information technology (IT), support staff, evaluation, and the Contractor's Association all support BHRS and network of care in the amount of $1,554,941.

Program	*Cost per year**
IT and Support Staff	$2,853,018
Communications and Language Access	$257,138
Contractor's Association	$218,670
CSS Evaluation	$217,627
CSS Planning	$151,952
CSS Admin	$740,449

OUTREACH AND ENGAGEMENT (O&E)

San Mateo's MHSA-funded Outreach and Engagement program strategy increase access and improves linkages to behavioral health services for underserved communities. Current programs under this component category will continue. BHRS has seen a consistent increase in representation of underserved communities in the system since these MHSA-funded strategies were deployed. Strategies include:

Pre-crisis response provides outreach, engagement, assessment, crisis intervention, case management and support services to individuals who are experiencing severe emotional distress and their families/caretakers.

The Cariño Project (formerly Coastside Multicultural Wellness) was founded on the opportunity to create new models of mental health and wellness wrap-around services for marginalized farmworker communities in the Coastside region of the county that are grounded in cultural arts frameworks of intervention. The program also engages individuals living with severe mental illness through support groups and community activities.

Adult Resource Management (ARM) provides early identification, engagement, and case management services to seriously mentally ill (SMI) adults who are homeless or at risk of becoming homeless.

Housing Locator, Outreach and Maintenance program will provide housing locator services provided by mental health counselors and peer navigators; the development and maintenance of a new BHRS Housing website with real-time housing availability information; linkages to BHRS case managers; and landlord engagement including community mental health awareness. Outreach and field-based services will be provided to support ongoing and long-term housing retention including a team of Occupational Therapist and Peer Counselor with co-occurring capacity to support independent living skills development

Homeless Engagement Assessment and Linkage (HEAL) program - Homeless Outreach partner certified treatment clinicians with the Homeless Outreach Team (HOT) team and Healthcare for the Homeless (HCH) outreach workers to bring a higher level of direct treatment and case management to the homeless out in the field. The HEAL team provides field-based mental health and addiction treatment, but also case management, referrals, and "warm hand-offs" to the regional health and street medicine services.

The San Mateo County Pride Center creates a welcoming, safe, inclusive, and affirming space for individuals of all ages, sexual orientations, and gender identities through education, counseling, advocacy, and support. The Pride Center takes a holistic approach to improving the health and wellbeing of the LGBTQ+ community by providing direct mental health services to individuals living with severe mental health challenges and individuals in the community seeking support groups, resources, community building activities and social and educational programming.

Projected number of people reached: 1620

Program	*Cost per year**	*# To be served*
Family Assertive Support Team	$373,768	100
The Cariño Project (20% CSS; 80% PEI)	$86,275	355
Adult Resource Management (ARM)	$1,823,274	295
Housing Locator, Outreach and Maintenance	$1,075,000	400
HEAL Program - Homeless Outreach	$325,000	300
The Pride Center (35% CSS; 65% PEI)	$267,718	170**

**This is the MHSA contribution and is not representative of the full cost of providing services*

***This number represents unduplicated clients receiving clinical care (therapy and case management); it does not represent the duplicated reach of over 4,000 individuals through peer groups, youth and older adult focused services, trainings, events and outreach interactions.*

PREVENTION AND EARLY INTERVENTION (PEI)

PEI targets individuals of all ages prior to the onset of mental illness, with the exception of early onset of psychotic disorders. PEI emphasizes improving timely access to services for underserved populations and reducing the 7 negative outcomes of untreated mental illness; suicide; incarcerations; school failure or dropout; unemployment; prolonged suffering; homelessness; and removal of children from their homes. Service categories include:

- Early Intervention programs provide treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Services shall not exceed eighteen months, unless the individual receiving the service is identified as experiencing first onset of a serious mental illness or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four years.
- Prevention programs reduce risk factors for developing a potentially serious mental illness and build protective factors for individuals whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members. Services may include relapse prevention and universal strategies.
- Outreach for Recognition of Early Signs of Mental Illness to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.
- Access and Linkage to Treatment are activities to connect individuals with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.
- Stigma and Discrimination Reduction activities reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services.
- Suicide Prevention programs are not a required service category. Activities prevent suicide but do not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness.

PREVENTION & EARLY INTERVENTION PROGRAMS

The following programs serve children and youth ages 0-25 exclusively and some combine both Prevention and Early Intervention strategies. MHSA guidelines require is 19% of the MHSA budget to fund PEI and 51% of PEI budget to fund program for children and youth.

EARLY CHILDHOOD COMMUNITY PROGRAM

Early childhood community program – supports healthy social emotional development of children through community outreach, case management, parent education, mental health consultation, and child-parent psychotherapy services to families with young children.

Projected number of children to be served: 60

Program	*Cost per year**	*# To be served*
Early Childhood Community Team (ECCT)	$483,496	60**

**This is the MHSA contribution and is not representative of the full cost of providing services*
***This number represents unduplicated children/families who are receiving one-on-one services, including direct therapy and groups; it does not represent the duplicated reach of over 150 parent/caregiver groups and teachers receiving consultation.*

COMMUNITY INTERVENTIONS FOR SCHOOL AGE AND TAY

School-Age Youth Programs – will serve children and youth in grades K-12 either administered by a school or a community-based organization in cooperation with schools. This program provides population and group-based interventions to at-risk children and youth, such as substance abuse programs, drop-in centers, youth focused and other organizations operating in communities with a high proportion of underserved populations.

Trauma-Informed Services for Youth (formerly Trauma-Informed Co-Occurring Services for Youth) target youth and transitional age youth (TAY) ages 15-25 who are at greatest risk for adverse childhood experiences; children of color and children who grow up in poverty show the greatest risk for ACEs. Other groups can include juvenile justice involved, immigrant youth, homeless youth, youth in foster care, etc. A group-based intervention utilizes evidence-based or promising practice intervention or curriculum to address trauma and co-occurring substance use issues with youth including the Mindfulness-Based Substance Abuse Treatment (MBSAT) or another culturally-relevant intervention/curriculum. A community engagement component addresses systemic and community-level challenges that are necessary for positive youth development and behavioral health outcomes.

INSPIRE (Innovative Strategies for Prevention and Intervention through Restorative Education), a brief intervention/alternative to suspension program effective in lowering youth suspension and expulsion rates. The project includes policy advocacy to address the equity implications of school district student disciplinary system.

Youth Crisis Response and Prevention provides crisis and suicide support to all ages of the San Mateo County community including a 24/7 Crisis Hotline, outreach and training, and mental health services including 24/7 crisis intervention and suicide prevention hotline for San Mateo County residents provided by trained volunteer/staff including peer phone counseling linkages to resources that may help. Services have expanded to youth and families in crisis through the *Youth Stabilization Opportunity and Support Program (Youth S.O.S.)*. This team, formerly known

as YIT, which Youth Intervention Team, which provides support to schools during crisis. This mobile crisis response team will also respond to the state-wide crisis program for current and former foster youth, as well as their caregivers through the Family Urgent Response System (FURS) program.

allcove Youth Drop-In Center creates stand-alone, "one-stop-shop" health centers for young people ages 12 to 25 to access support for mild to moderate needs with mental health, physical health, substance use, peer support, supported education and employment, and family support, as well as linkages to community referrals in the continuum of care for more intensive needs. allcove approaches youth wellness in a comprehensive and youth-friendly way, led by members of an active local Youth Advisory Group, who help design the services and environment they most want to see in their community, and a Community Consortium.

Projected number of school-age youth to be served: 17,060

Program	*Cost per year**	*# To be served*
Trauma-Informed Services for Youth	$520,000	285**
Brief Intervention Model (INSPIRE)	$100,000	75
Youth Crisis Response and Prevention	$333,691	15,700
allcove Youth Drop-In Center	$500,000	1,000

**This is the MHSA contribution and is not representative of the full cost of providing services*
***This number represents unduplicated youth who participated in group-based interventions; it does not represent the duplicated reach of over 320 adults (parents, teachers, probation officers, service providers, community, etc.) that receive foundational trauma-informed 101.*

PREVENTION PROGRAMS

Trauma-Informed Systems (Ages 0-5) is a multi-sector initiative to transform service delivery for young children and their families. The Trauma- and Resiliency-Informed Systems Initiative (TRISI) is a countywide effort to integrate a comprehensive commitment to address trauma and promote resiliency into local programs, structures, and culture with a long-term goal of embedding trauma- and resiliency-informed policies and practices at every level of the system.

COMMUNITY OUTREACH, ENGAGEMENT AND CAPACITY BUILDING

Substance Use Prevention efforts under the BHRS Alcohol and Other Drug Services, Community Health Promotion Unit are focused on three culturally appropriate community assessments to identify factors that contribute to alcohol and other drug use amongst African American, Latinx, and Tongan communities. Community partners will develop a set of recommendations and a comprehensive longer-term plan based on the findings of the assessment and begin implementation activities. Other activities include pivoting the BHRS Cannabis Decoded and Crushing the Curve campaigns into a youth development effort that is inclusive of additional

topics such as mental health, methamphetamine, opioids/fentanyl, etc. The campaign includes a website, Instagram, TikTok created by youth, placed ads on youth-frequented sites, outdoor placement, influencers, etc.

Additionally, this effort includes a Community Health Planner position to conduct outreach and engage community in discussions, education and health promotion around trending co-occurring mental health and substance use issues. Build partnership with local school districts, faith based communities, prevention partnerships, and other community groups to ensure active engagement and community oriented activities.

Office of Diversity and Equity (ODE) programs –ODE advances health equity in behavioral health outcomes of marginalized communities throughout San Mateo County. ODE works to empower communities; influence policy and system changes; develop strategic and meaningful partnerships; and promote workforce development and transformation within the County's behavioral health service system. ODE has oversight of MHSA Administration, BHRS Workforce Education and Training, Prevention and Early Intervention (PEI) coordination and some PEI programming. The current PEI programs under ODE that will continue include the Health Equity Initiatives, Health Ambassador Programs for Adult and Youth, Storytelling, Mental Health First Aid for adults and youth and the Parent Project.

Projected number of people reached through the following core ODE programs: 5,115

Program	*Cost per year*	*# To be served*
Trauma-Informed Systems (Ages 0-5)	$150,000	350
Substance Use Prevention	$677,305	1,800
Office of Diversity and Equity	$483,247	N/A
Health Equity Initiatives	$333,739	2,800
Health Ambassador Program	$165,024	25
Health Ambassador Program - Youth	$304,115	30
Parent Project	$288,787	110

RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

Mental Health First Aid (MHFA) – to introduce participants to the unique risk factors and warning signs of mental health problems in adults, build understanding of the importance of early intervention, and teaches individuals how to help an individual in crisis or experiencing a mental health challenge. Youth MHFA is currently funded by a local tax revenue, Measure K and is being proposed to be sustained with MHSA funding moving forward.

Projected number of individuals served: 200

Program	*Cost per year*	*# To be served*
MHFA – Youth, Teen, Adult	$322,291	200

STIGMA AND DISCRIMINATION REDUCTION

Digital Storytelling and Photovoice - empowers community members to share their stories of recovery and wellness to heal and to address issues within their communities. Participants engage in workshops that help them create and share their stories in different forms. Beginning with a framing question, facilitators support participants to share their stories as Photovoices or Digital Stories.

Mental Health Awareness - is an initiative by San Mateo County's Behavioral Health and Recovery Services (BHRS) to eliminate stigma and end the discrimination against people with mental illness and substance use issues in San Mateo County.

Projected number of people reached: 550

Program	*Cost per year*	*# To be served*
Digital Storytelling and Photovoice	$131,529	50
Mental Health Awareness; Be the One Campaign	$175,486	500

SUICIDE PREVENTION

Suicide Prevention Initiative - For over three years, San Mateo County has convened a Suicide Prevention Committee that has examined ways to improve policies and systems to prevent suicide. The Committee is comprised of both BHRS staff and community members, and address issues such as community mental health education and awareness, gatekeeper trainings, and provider trainings on suicide ideation and intervention. Activities have included suicide prevention presentations at agencies and community meetings, partner meetings with the County Office of Education, and data updates.

California Mental Health Services Authority (CalMHSA) implements PEI Statewide Projects including Suicide Prevention, Stigma and Discrimination Reduction, and the Student Mental Health Initiative. CalMHSA is a Joint Powers Authority (JPA), formed July 2009 as solution to providing fiscal and administrative support in the delivery of mental health services. San Mateo County historically contributed 2% of PEI funding for sustainability of these projects; the contracting has shifted to a multi-year agreement at $225,000 contribution per year.

Projected number of people reached: 800

Program	*Cost per year*	*# To be served*
Suicide Prevention Roadmap; PEI Statewide	$205,486	800

EARLY INTERVENTION PROGRAMS

911 mental health assessment and referral - specially trained paramedic responds to law enforcement requests for individuals having a behavioral health emergency.

Integration with primary care –identifies persons in need of behavioral health services in the primary care setting, connecting people to needed services. Strategies include system-wide co-location of BHRS practitioners in primary care environments to facilitate referrals, perform assessments, and refer to appropriate behavioral health services.

Early psychosis provides a comprehensive program of science-based early diagnosis, treatment, and rehabilitation services for psychotic disorders such as schizophrenia. This program aims to prevent the onset of full psychosis, and, in cases in which full psychosis has already occurred, seeks to remit the disease and to rehabilitate cognitive capacities damaged by the disease.

Projected number of individuals served

Program	*Cost per year **	*# To be served*
San Mateo Mental Health and Referral Team (SMART)	$134,529	560
Primary Care Based Programs (Primary Care Interface; Ravenswood)	$1,104,276	1,590
Early Psychosis Program – (re)MIND	$589,164	80
Crisis Response (Adult S.O.S.)	$650,000	

**This is the MHSA contribution and is not representative of the full cost of providing services*

ACCESS AND LINKAGE TO TREATMENT

Community outreach collaboratives are intended to facilitate a number of activities focused on community engagement, including outreach and education efforts aimed at decreasing stigma related to mental illness and substance abuse; increasing awareness of and access to behavioral health services; advocating for the expansion of local resources; gathering input for the development of MHSA-funded services; linking and referring residents to culturally and linguistically competent behavioral health, public health and social services; and providing input into the development of MHSA funded services and other BHRS program initiatives.

Coastside community engagement – provides culturally-responsive outreach to the Coastside community. Primarily services are provided through outreach workers (promotores) with shared lived experience with the Coastside and familiarity with behavioral health resources to conduct outreach and engagement, provide referrals, warm hand-offs, mental health information, and education, collaborate with BHRS staff, and identify community-based entities, health and social service providers and other resources. Community engagement also includes ongoing community capacity building, including youth leadership development that focuses on advocacy and system change.

Peer Counseling and adult outreach – to create integrated services for older adults to assure that there are sufficient supports to maintain the older adult population in their homes and

community, in optimal health and sustaining independence and family/community connections.

The San Mateo County Pride Center creates a welcoming, safe, inclusive, and affirming space for individuals of all ages, sexual orientations, and gender identities through education, counseling, advocacy, and support. The Pride Center takes a holistic approach to improving the health and wellbeing of the LGBTQ+ community by providing direct mental health services to individuals living with severe mental health challenges and individuals in the community seeking support groups, resources, community building activities and social and educational programming.

Projected number of people reached: 9,520

Program	*Cost per year*	*# To be served*
North County Outreach Collaborative	$348,198	4,500
East Palo Alto Partnership for Behavioral Health	$222,569	1,500
Coastside Community Engagement	$506,027	3,000
The Pride Center (35% CSS; 65% PEI)	$267,718	170**
Peer Counseling (50%); Older Adult Outreach	$413,727	350

**This is the MHSA contribution and is not representative of the full cost of providing services*
***This number represents unduplicated clients receiving clinical care (therapy and case management); it does not represent the duplicated reach of over 4,000 individuals through peer groups, youth and older adult focused services, trainings, events and outreach interactions.*

Infrastructure- PEI and ODE administration and supplies, planning and evaluation expenditures total $863,776.

Program	*Cost per year*
PEI Admin	$439,752
PEI Planning	$170,207
PEI Eval	$367,662

INNOVATION (INN)

INN projects are designed and implemented for a defined time period (not more than 5 years) and evaluated to introduce a behavioral health practice or approach that is new; make a change to an existing practice, including application to a different population; apply a promising community-driven practice or approach that has been successful in non-behavioral health; and has not demonstrated its effectiveness (through mental health literature). The State requires submission and approval of INN plans prior to use of funds.

NEW INNOVATION PROJECTS

On February 14, 2023, the San Mateo County Board of Supervisors (BOS) approved 4 new INN projects and they were subsequently submitted and approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) on February 23, 2023. The BoS approved versions were submitted with an Amendment to the FY 2023-24 MHSA Annual Update. These projects are all anticipated to launch July 1, 2023.

1. *Adult Residential In-Home Support Element (ARISE)*. The ARISE program creates a model for residential in-home services to support clients with a serious mental illness (SMI) and/or substance use disorder (SUD) who are at risk of losing their housing. Residential in-home support workers—approved in-home support services (IHSS) providers—will be provided with specialized training for working with SMI and/or SUD clients in collaboration with a peer support staff and occupational therapist.
2. *Mobile Behavioral Health Services for Farmworkers.* The program will provide direct behavioral health mobile services and wraparound resources in Spanish to farmworkers and their families. It integrates cultural arts practices as a pathway for engaging farmworkers and their families with formal clinical behavioral health services spanning prevention, early intervention, treatment, and recovery.
3. *Music Therapy for Asians and Asian Americans.* Service provider: This project will provide music therapy as a culturally responsive approach for Asian/Asian Americans to reducing stigma, increasing behavioral health literacy, and promoting linkages to behavioral health services and building protective factors to prevent behavioral health challenges and crises.
4. *Recovery Connection Drop-in Center.* This center will provide drop-in services for individuals with substance use challenges or co-occurring substance use and mental health challenges at all stages of their recovery, from pre-contemplative to maintenance and enhancement. The Recovery Connection will center around Wellness Recovery Action Plan (WRAP) programming, use a peer support model, provide linkages as needed and serve as a training center to expand capacity countywide.

PREVIOUSLY APPROVED INNOVATION PROJECTS

1. *Kapwa Kultural Center (KKC) and Cafe* introduces a social enterprise business model; a revenue generating endeavor to fund social causes. KKC will generate profit through the sale of boba tea and food items, to support the sustainability of youth-focused services, including youth development, culturally-specific education and arts, and behavioral health services. The cafe and physical location will serve as a culturally affirming space for the Filipino/a/x community; soft opening is anticipated September 2023.

2. *PIONEERS - Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve* will provide culturally relevant, behavioral health support for Native Hawaiian/Pacific Islanders (NHPI) youth and young adults, ages 14–25. The PIONEERS Program will address wellness and behavioral health needs, as informed by a Youth Advisory Council of NHPI youth, young adults and leaders. This project is anticipated to launch July 1, 2023.

3. *Co-location of Prevention and Early Intervention Services in Low-Income Housing* intended to provide prevention and early intervention services including behavioral health resources, supports, screening, referrals and linkages to young adults, ages 18-25, on-site at affordable housing properties.

   After going out to a Request for Proposal (RFP) process and receiving no proposals, one interested bidder informed BHRS that they did not have the staff capacity, nor partner buy-in, to submit a bid. After consultation with procurement, the bidding process remained open for another two weeks. The interested bidder then informed us that they would not be able to commit to the project. This Annual Update serves as notification that this project will be terminated prior to start and as of June 30, 2023.

Annual projected number of participants served through INN projects: 1,420

Program	*Cost (FY 2022-23)*	*# To be served*
Kapwa Kultural Center and Cafe - Social Enterprise	$522,148	150*
PIONEERS Program	$238,220	25
Adult Residential In-home Support Element (ARISE)	$330,000	35
Mobile Behavioral Health - Farmworkers	$485,000	150
Music Therapy for Asian/Asian Americans	$255,000	160
Recovery Connection Drop-In Center	$500,000	450
Admin/Overhead	$215,000	N/A
INN Evaluation	$231,000	N/A

**This number represents unduplicated clients receiving clinical behavioral health care; it does not represent the duplicated reach of over 6,000 individuals through outreach.*

WORKFORCE EDUCATION & TRAINING (WET)

In FY 2006-07 and FY 2007-08, San Mateo County Behavioral Health and Recovery Services (BHRS) received a one-time MHSA allocation in the amount of $3,437,600, for Workforce Education and Training (WET) strategies. A WET 10-Year Impact and Sustainability Report was developed in 2018 recommending sustainability of WET staffing, system transformation training

and trainings for/by peers. Since the work under WET has significantly grown and allocations have increased each year with stakeholder input and community program planning processes approvals.

This MHSA Three-Year Plan prioritizes Behavioral Health Workforce as an area of need given the nationwide shortage of behavioral health staff and increased behavioral health needs post the pandemic. The following are the recommendations provided by stakeholders during the Community Program Planning process, listed in order prioritized by the MHSA Steering Committee.

Behavioral Health Workforce

- Implement recruitment and retention financial incentives such as retention bonuses, signing bonuses, educational loanrepayment for staff and contracted providers.
- Implement supports for direct service staff, including peers, to advance in their careers, specifically BIPOC staff (e.g.,scholarships to pursue licensure/credentials, mentorship).
- Invest in support, retention and leadership development of peer and family support workers (training, fair compensation,career ladders, flexible hours, and mentorship).
- Target recruitment activities to reach black, indigenous, people of color (BIPOC) communities (e.g., partner withBIPOC-focused communities and student organizations and networks).
- Research, plan, and implement compensation and benefits that are aligned with competing agencies and neighboring counties (e.g., salaries, cost of living, retirement plans, housing vouchers).
- Create a pipeline program focused on increasing Asian American and African American behavioral health staff, develop partnerships with local and neighboring academic and non-academic programs.
- Explore opportunities for alternative and flexible schedules and remote work.
- Create more entry level positions and internships for students of diverse backgrounds; streamline hiring processes(e.g., onboarding and process to hire interns).
- Examine and adjust caseload size and balance, particularly for bilingual staff.
- Expand type, flexibility, and access to staff wellness and engagement opportunities (e.g., appreciation, healing activities, mentoring, behavioral health supports, networking events).
- Address extra help and contracted positions, especially for those that interface with the community.

GREATER BAY AREA REGIONAL PARTNERSHIP

The California Department of Health Care Access and Information (HCAI), formerly Office of Statewide Health Planning and Development (OSHPD), in coordination with the California Behavioral Health Planning Council (CBHPC), is charged with the development of a statewide

WET Plan every five years to address the needs of the behavioral health workforce. In February 2019, OSHPD released a 2020-2025 MHSA WET Five-Year Plan. Regional Partnerships were funded with a local one-time MHSA match requirement to implement strategies in pipeline development, undergraduate scholarships, education stipends, and educational loan repayments. Thirty-five eligible BHRS employees and contracted providers were awarded up to $15,000 toward repayment of educational loans in exchange for a 12-month service obligation.

WET THREE-YEAR PLAN

A WET Three-Year Plan was developed with input from key stakeholders, see Appendix 6 for the full plan; priorities include:

System-wide Trainings includes 3 BHRS employees (WET Director, BHRS Internship Program Coordinator and Community Program Specialist – WET Training Support) to staff the WET program activities and support the administration of trainings to BHRS staff. Trainings for system transformation increase the capacity of providers to respond to behavioral health issues and includes training topics related to culturally informed practices, evidence-based practices, peer trainings, multicultural organization development, diversity, equity, and inclusion (DEI), and other specialty topics (eating disorders, hoarding, etc.).

Recruitment/Retention Programs include pipeline programs, educational loan repayment and other recruitment and retention financial incentives, peer leadership development, and scholarships to pursue advanced degrees/licensure/credentials.

Training for/by Consumer (Lived Experience Academy, Advocacy Academy, Peer Leadership) include strategies focused on peer training opportunities, certification, continuing education, and leadership development to support peers to meaningfully engage in BHRS decision-making spaces and career advancement.

Program	*Cost per year*
System-wide Trainings	$1,500,000
Recruitment/Retention Program	$500,000
Training for/by Consumer (LEA, Advocacy Academy, Peer Leadership)	$280,000

CAPITAL FACILITIES & TECHNOLOGY NEEDS (CFTN)

In the early implementation years of MHSA, through a robust stakeholder process, it was decided to focus all resources of this component to fund eClinical Care, an integrated business and clinical information system (electronic health record) as well as ongoing technical support. The system continues to be improved and expanded in order to help BHRS better serve the clients and families of the San Mateo County behavioral health stakeholder community.

Until recently, there had been no allocated funding to ongoing CFTN needs. The One -Time Plan presented in the Fiscal Summary section of this MHSA Three-Year Plan includes CFTN priorities to renovate County-owned facilities and acquire property.

Client Devices provide technology supports (devices and data plans), for clients and family members of clients that would benefit from telehealth and/or other behavioral health services but do not have the resources to purchase the technology needed and accessories (hotspots, headphones, screen protectors, styluses, etc.) that support clients' use of the technology for behavioral health supports. The digital divide experienced by clients was impacted by both the lack of technology devices and the knowledge on how to use the technology. BHRS also offers basic technology supports for clients via a virtual and over-the-phone IT Ticket System and digital literacy training for peer staff through a contract with Painted Brain, a peer run organization with technology expertise.

Client Device Applications (Apps) support client wellness and treatment goals and have been piloted successfully through the Help@Hand Innovation project and the BHRS Alcohol and Other Drug (AOD) unit to support those with opioid and/or substance addiction. AOD piloted Pear Therapeutics, the first FDA approved "Prescription Digital Therapeutic" (PDT) app for smart phones, substance use providers and addiction medicine specialists prescribed the app to client. PDT recently closed down operations and the AOD team is looking to find a replacement. With support from county clinicians and peer staff, a total of 31 of San Mateo County's adult, older adult and transition-age youth clients tested Wysa app and shared their positive experience with the app. Wysa will be implemented more broadly with behavioral health clients.

Program	*Cost per year*
Client Devices	$330,000
Client Device Applications (Apps)	$300,000

ANNUAL UPDATE

FY 2023-2024

(Includes program highlights and data from FY 2021-22 services)

ANNUAL UPDATE FY 2023-24 (DATA FROM FY 2021-22)

Welfare and Institutions Code Section (WIC) § 5847 states that county mental health programs shall prepare and submit an Annual Updates for Mental Health Service Act (MHSA) programs and expenditures. The Annual Update includes any changes to the Plan and expenditures. This Annual Update will focus on presenting the latest set of full FY 2021-22 data, including program and fiscal planning highlights and updates, grievance data, program outcomes, and evaluation reports.

MHSA WORKGROUPS

INNOVATION WORKGROUP

The MHSA Steering Committee hosts up to two small workgroups per year focused on a specific MHSA topic that is aligned with MHSA planning needs and may require more intensive planning, improvements, evaluation and/or other recommendations (e.g., housing, full service partnerships, innovation, community program planning, etc.). The workgroups are open to public participation, are time-limited and 10-12 participants are selected via an interest survey.

Between February and April 2022, a workgroup was convened made up of diverse stakeholders including clients, family members, community members, service providers and BHRS staff. The workgroup met monthly to develop an idea submission and stakeholder participation process that is as *inclusive* and as *accessible* as possible so that a broad range of community members would submit project ideas.

Innovation Workgroup Members (12 were selected, 8 attended regularly)

Participant	Organization and/or Affiliations	Stakeholder Group
Lanajean Vecchione	Advocacy Academy, Help@Hand Advisory, Diversity and Equity Council, Suicide Prevention Committee, Lived Experience Education Workgroup (LEEW)	Client/consumer of mental health services; Families of clients/consumers
Jean Perry	Behavioral Health Commission, LEEW, NAMI, League of Women Voters CA	Families of clients/consumers
Carol Gosho	NAMI San Mateo County	Families of clients/consumers
Amanda Pyle	Golden Gate Regional Center, All in for Equitable Care (Marin)	Provider of other social services; Disabilities
Vicky Avila Medrano	Nuestra Casa East Palo Alto	Families of clients/consumers; Provider of other social services; Immigrants
Marina Kravtsova	San Mateo Adult and Career Education	Adult Education; Immigrants
William Elting	LEEW, Advocacy Academy, Crisis Center, Seeing Through Stigma, One New Heartbeat	Client/consumer of mental health services
Karla Papula	Outlet (LGBTQI Youth Services) of Adolescent Counseling Services	Client/consumer of mental health services; Families of clients/consumers; Providers of behavioral health services; LGBTQIA

The INN Workgroup was facilitated Doris Estremera, MHSA Manager and independent consultant, Alison Hamburg. Based on ideas from the workgroup the following materials, sessions and activities were developed:

- Frequently Asked Questions (FAQ) about INN and requirements for INN projects
- Myth Busters to demystify the submission process
- Submission Packet (*translated into Spanish and Chinese*) including scoring criteria and a user friendly online and fillable form, which asked submitters to describe how their project addressed the MHSA Core Values and the MHSA Three-Year Plan prioritized needs. The Community Program Planning (CPP) process for the MHSA Three-Year Plan included a comprehensive community needs assessment to determine the gaps, needs and priorities for services.
- Outreach Plan to inform community members about the opportunity to submit ideas.
    - Announcements at numerous internal and external community meetings and program activities engaging diverse families and communities (Parent Project, Health Ambassador Program, Lived Experience Academy, etc.)
    - E-mails disseminating information to over 3,000 stakeholders
    - Word of mouth on the part of committed staff and active stakeholders
    - Postings on a dedicated MHSA webpage and the monthly BHRS Director's Update.
- Online Info Session and "How to Conduct Online Research" training, which were recorded and posted on the MHSA website.
- Technical Assistance sessions where potential submitters could talk through their idea(s).

Nineteen (19) ideas were submitted and pre-screened against the INN requirements. Of these, 14 ideas moved forward to a selection group made up of BHRS staff, nonprofit providers, and people with lived experience, who reviewed the ideas and scored them based on the identified criteria. An internal feasibility review was conducted that included preliminary feedback from the Mental Health Oversight and Accountability Commission (MHSOAC). Four (4) ideas were developed into full INN Project Plans.

On October 6, 2022, the MHSA Steering Committee reviewed the 4 INN project ideas and provided considerations for the projects through breakout room discussions and on-line comment forms. The Behavioral Health Commission (BHC) voted to open the 30-day public comment period on November 2, 2022, and held a public hearing at closing of the public comment period on December 7, 2022.

The 4 INN Projects were approved by the San Mateo County Board of Supervisors on February 14, 2023, as part of an Amendment to the MHSA Annual Update for Programs and Expenditures Fiscal Year 2022-23

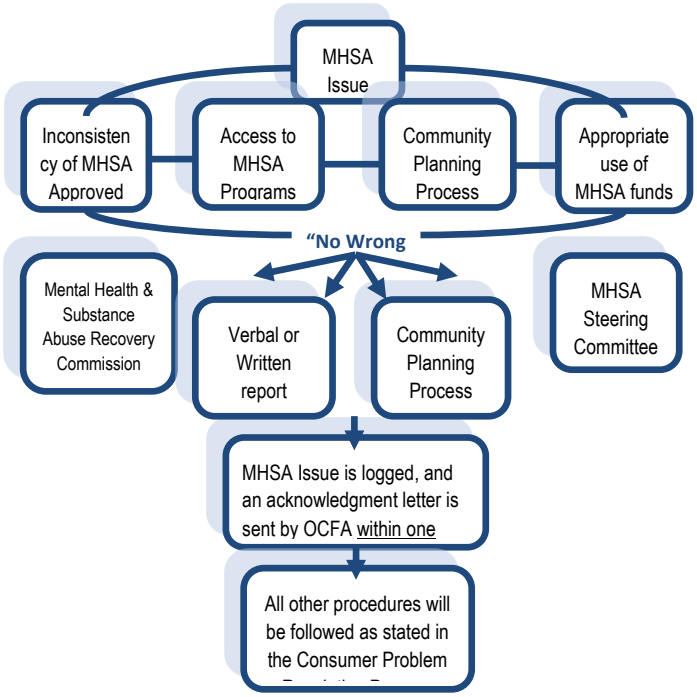
and subsequently submitted to DHCS and MHSOAC as is required by the legislation guidelines. The projects were approved by the MHSOAC on February 23, 2023. A local Request for Proposal process followed to support an open procurement process for the services and the following agencies were selected to implement the 4 INN Projects starting July 1, 2023.

- *Adult Residential In-Home Support Element (ARISE)*. Service provider: Mental Health Association (MHA). Total amount proposed: $1,235,000 for 4 years ($990K services, $145K admin, $100K eval). The ARISE program creates a model for residential in-home services to support clients with a serious mental illness (SMI) and/or substance use disorder (SUD) who are at risk of losing their housing. Residential in-home support workers—approved in-home support services (IHSS) providers—will be provided with specialized training for working with SMI and/or SUD clients in collaboration with a peer support staff and occupational therapist.
- *Mobile Behavioral Health Services for Farmworkers.* Service provider: Ayudando a Latinos a Soñar (ALAS). Total amount proposed: $1,815,000 ($1.455M services, $215K BHRS admin, $145K evaluation). The program will provide direct behavioral health mobile services and wraparound resources in Spanish to farmworkers and their families. It integrates cultural arts practices as a pathway for engaging farmworkers and their families with formal clinical behavioral health services spanning prevention, early intervention, treatment, and recovery.
- *Music Therapy for Asians and Asian Americans.* Service provider: North East Medical Services (NEMS). Total amount proposed: $940,000 for 4 years ($755K services, $110K admin, $75K evaluation). This project will provide music therapy as a culturally responsive approach for Asian/Asian Americans to reducing stigma, increasing behavioral health literacy, and promoting linkages to behavioral health services and building protective factors to prevent behavioral health challenges and crises.
- *Recovery Connection Drop-in Center.* Service provider: Voices of Recovery (VoR) San Mateo County. Total amount proposed $2,840,000 for 5 years ($2.275M services, $340K BHRS admin, $225K evaluation). This center will provide drop-in services for individuals with substance use challenges or co-occurring substance use and mental health challenges at all stages of their recovery, from pre-contemplative to maintenance and enhancement. The Recovery Connection will center around Wellness Recovery Action Plan (WRAP) programming, use a peer support model, provide linkages as needed and serve as a training center to expand capacity countywide.

ISSUE RESOLUTIONS

MHSA Issue Resolution Process (IRP)

The purpose of the MHSA IRP is to resolve process-related issues with 1) the MHSA Community Program Planning (CPP) process; 2) consistency between approved MHSA plans and program implementation; and 3) the provision of MHSA funded programs.



In San Mateo County, the MHSA IRP (BHRS POLICY: 20-10) is integrated into the broader BHRS Problem Resolution Process facilitated by the Office of Consumer and Family Affairs (OCFA) to support clients in filing grievances about services received from BHRS or contracted providers, ensuring that client issues are heard and investigated. BHRS clients receive client rights information upon admission to any program, which includes information on the right to a problem resolution process and how to file a grievance, appeal or request a state fair hearing after exhausting the internal problem resolution process.

For the FY 2021-22 reporting year of this MHSA Annual Update, there were 14 quality of care-related grievances filed with the BHRS Office of Consumer and Family Affairs (OCFA) for MHSA funded programs. There were 0 MHSA process-related grievances.

Category of grievance (FY 2021-22)	**# of grievances**	**Outcome** (from the client's perspective: was the outcome Favorable, Partially Favorable, Not Favorable?)
Access: Services Not Available	1	Favorable
Other: Financial	2	1 Favorable, 1 Not favorable
Other: Operational	1	Favorable
Other: Peer behavior	1	Partially favorable
Medication concerns	1	Not favorable
Staff behavior	28	19 Favorable, 2 Not favorable, 7 Partially favorable
Treatment concerns	5	3 Favorable, 2 Not favorable

EVALUATION ACTIVITIES

PREVENTION AND EARLY INTERVENTION DATA COLLECTION FRAMEWORK

An independent consultant, Resource Development Associaties (RDA), provided outcome data planning and technical assistance for PEI programs that provide some component of individual-level services to better align with the June 2018 Mental Health Services Oversight and Accountability Commission (MHSOAC) updated reporting requirements for the MHSA Prevention and Early Intervention (PEI) component. The new reporting requirements focus on individual demographics, referrals and access to treatment, and individual outcomes.

The project aimed to develop a reporting framework to **identify PEI data and individual outcomes** that could be analyzed across all PEI programs to demonstrate a collective impact. A PEI Data Collection and Reporting Framework (see Appendix 7) was developed and includes highlights the key decisions points that were made to inform the framework, and visual summaries of how the currently funded PEI programs will be reporting individual data and outcomes.

ONGOING EVALUATION REPORTS

Independent evaluation consultants are procured to provide ongoing annual evaluation reports for Full Service Partnerships (FSP), Prevention and Early Intervention (PEI) Outreach Collaboratives and Innovation projects. Appendix 8, 9, 10, and 11 includes the completed final evaluation reports as follows:

- FSPs - American Institutes for Research (AIR) analyzes FSP data for youth, transition age youth and adults to understand how enrollment in the FSP is promoting resiliency and improved health outcomes of clients living with a mental illness. Appendix 8 includes the completed FSP Evaluation Report.

- Outreach Collaboratives - AIR also supports evaluation and analyses of the PEI Outreach Collaboratives. See Appendix 9, Outreach Collaborative Evaluation Report.

- Innovation (INN) – FY 2021-22 active INN Projects in San Mateo County included:
    - Help@Hand (Tech Suite), Appendix 10
    - Kapwa Kultural Center and Cafe (Social Enterprise Cafe), Appendix 11

  Resource Development and Associates developed an evaluation plan for both of these projects and has been collecting ongoing data. See Appendix 10 and 11 for the FY 2021-22 INN Evaluation Reports including the CalMHSA statewide Help@Hand Evaluation.

COMMUNITY SERVICES & SUPPORTS (CSS)

FULL SERVICE PARTNERSHIPS (FSP)

Within San Mateo County, the initial Full Service Partnerships (FSP) programs, Edgewood, Fred Finch, and Telecare, have been fully operational since 2006. A fourth site, Caminar 's Adult FSP, was added in 2009. FSP programs do "whatever it takes" to help seriously mentally ill adults, children, transition-age youth and their families on their path to recovery and wellness. Edgewood Center and Fred Finch Youth Center serve children, youth and transition age youth (C/Y/TAY) using the Wraparound model and Caminar and Telecare offer Assertive Community Treatment (ACT) services to adults, older adults, and their families.

The cost figures below do not speak to the span or quality of services available to clients either through BHRS or through contracted providers and may overlook important local issues such as the cost of housing, supported services provided, etc.

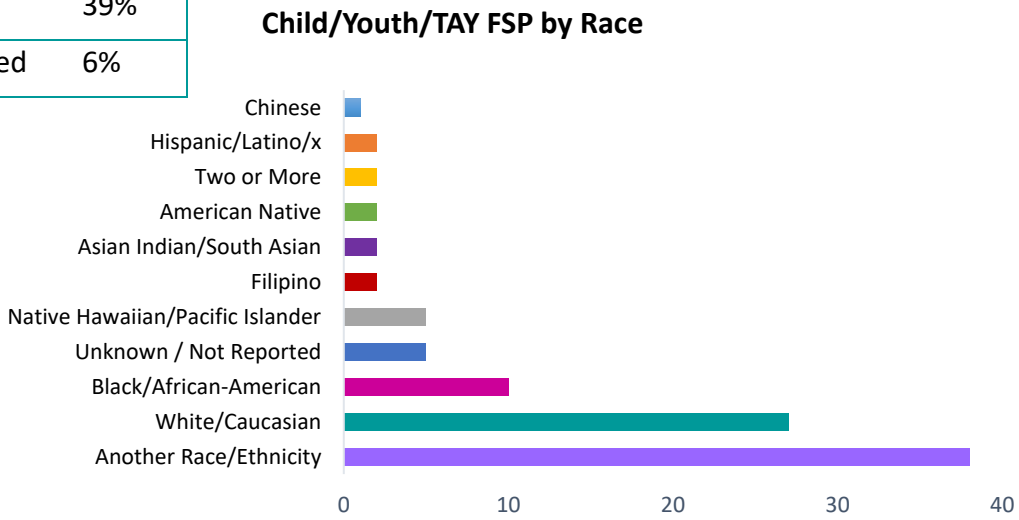
Program	FY 2021-22 FSP slots	FY 2021-22 clients served	Cost per client*	Cost per slot
Children/Youth (C/Y) FSP's				
Out-of-County Foster Care Settings FSP	10	5	$10,000	$5,000
Integrated FSP "SAYFE" FSP	25	68	$15,978	$43,459
Comprehensive FSP "Turning Point"	40	110	$25,843	$71,067
Transitional Age Youth (TAY) FSP's				
Comprehensive FSP "Turning Point" FSP	50	167	$17,022	$56,854
Adult/Older Adult FSP's				
Adult and Older Adult/Medically Fragile FSP	207	257	$9,126	$11,330
Comprehensive FSP	30	33	$57,136	$62,849
Assisted Outpatient Treatment (AOT) FSP	50	64	$6,368	$12,444
South County Clinic Embedded FSP	15	20	$6,368	$8,491

*Calculated based on clients served during the fiscal year and the MHSA funding contribution only (not including housing); this is not representative of the full cost of providing services. There are also reimbursements and other revenues sources associated with FSP's that may decrease the final MHSA funding contribution.

FSP Race/Ethnicity Demographics

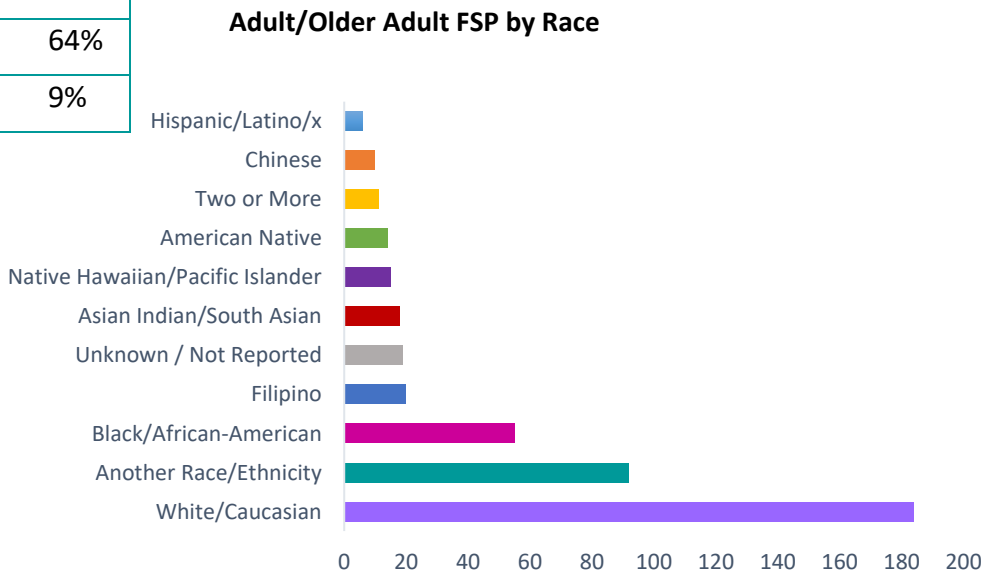
Child/Youth and Transition Age Youth FSP Client Demographics
FY 2021-22 (total clients = 96)

Percent of FSP Clients by Ethnicity	
Hispanic or Latino	55%
Not Hispanic or Latino	39%
Unknown / Not Reported	6%



Adult and Older Adult FSP Client Demographics
FY 2021-22 (total clients = 334)

Percent of FSP Clients by Ethnicity	
Hispanic or Latino	27%
Not Hispanic or Latino	64%
Unknown / Not Reported	9%



FSP Performance Outcomes by Age Group

As part of San Mateo County's implementation and evaluation of the FSP programs an independent consultant analyzes FSP data to understand how enrollment in the FSP is promoting resiliency and improved health outcomes of clients living with a mental illness. Year-to-year outcomes are tracked for individual clients in FSPs. Information collected for FSPs include data in 10 domains: residential (e.g., homeless, emergency shelter, apartment alone) education (e.g., school enrollment and graduation, completion dates, grades, attendance, special education assistance), employment, financial support, legal issues, emergency interventions, health status, substance use, and for older adults, activities of daily living. Data from FSP participants is collected by providers via self-reported intake assessment, key event tracking and 3-month assessments. See Appendix 8 for the full FSP Evaluation Report for FY 2021-22. The tables below present a highlight of the percent improvement between the year just prior to FSP and the first year with FSP, by age group.

FSP outcomes	**Adult (25 to 59 years)**			**Older adult (60 years and older)**		
Self-reported outcomes	***N = 114***			***N = 23***		
	Yr. before	*Yr. after*	*Change*	*Yr. before*	*Yr. after*	*Change*
Homelessness	47 (41%)	34 (30%)	-28%	5 (22%)	3 (13%)	-40%
Detention or incarceration	35 (31%)	22 (19%)	-37%*	4 (17%)	3 (13%)	-25%
Employment	1 (1%)	4 (4%)	300%	0 (0%)	0 (0%)	N/A
Arrests	20 (18%)	4 (4%)	-80%*	4 (17%)	1 (4%)	-75%
Mental health emergencies	84 (74%)	31 (27%)	-63%*	13 (57%)	4 (17%)	-69%*
Physical health emergencies	50 (44%)	17 (15%)	-66%*	7 (30%)	4 (17%)	-43%
Active Substance Use Disorder (SUD)	61 (54%)	57 (50%)	-7%	5 (22%)	4 (17%)	-20%
SUD treatment	27 (24%)	33 (29%)	22%	3 (13%)	2 (9%)	-33%
Health care utilization (Electronic Health Care data)	***N = 360***			***N = 75***		
	Yr. before	*Yr. after*	*Change*	*Yr. before*	*Yr. after*	*Change*
Hospitalization	125 (35%)	57 (16%)	-54%*	22 (29%)	12 (16%)	-45%
Hospital days per partner	12.4	4.0	-68%*	10.5	4.6	-57%
Psychiatric Emergency Services (PES)	196 (54%)	140(39%)	-29%*	32 (43%)	19 (25%)	-41%*
PES event per partner	1.7	1.1	-37%*	1.1	0.5	-51%

Note. For self-reported outcomes, there are only 23 older adult partners; caution is recommended when interpreting results with small sample size. The percent difference with employment for older adults is reported as N/A because the percentage of older partners with employment was 0% in the Yr. before (from 0% to 0%). Thus, the denominator is 0. Blue font indicates outcomes that improved. Black font indicates outcomes did not change or changed but the change was not statistically significant. *Indicates a change significantly different from 0 at 0.05 significance level.

CHILDREN AND YOUTH (C/Y) FSP

INTEGRATED FSP "SAYFE"

The Short-Term Adjunctive and Family Engagement (SAYFE) program is designed to support the county's most vulnerable youth and their families to maintain and improve the youth's placement. In congruence with Edgewood Center's mission and values, the Full-Service Partnership (FSP) work is informed by a core belief that children, youth, and families are best served and supported in the context of their unique family system, culture, and community. SAYFE serves 25 of the highest risk children/youth living in San Mateo County at any one time by augmenting and extending the clinical work and existing treatment plan within: (1) the outpatient and Therapeutic Day School (TDS) programs and (2) clients who are currently being served by Behavioral Health and Recovery Services (BHRS) in a county clinic.

Youth are primarily referred to the SAYFE program through Human Services Agency (HSA)- child welfare, Juvenile Probation, San Mateo County Clinics, and Schools (typically with an Individualized Education Program – IEP for emotional disturbance). The treatment is provided to help stabilize youth in their home environment and prevent (or transition back from) a higher level of care (e.g., psychiatric hospital, residential facility, juvenile hall, etc.). All programs under the umbrella of the Youth FSP are guided by a strong belief in:

1. Service Integration: Communities are strengthened by a family-centered network of services and providers that partner with children, youth, and families and
2. Local Focus: Children, youth, and families receive the highest quality of care when services are provided and accessible within their community.

The Youth Full-Service Partnership (FSP) Program services are open to all youth meeting the population criteria below. However, it is specifically targeted to Asian/Pacific Islander, Latino, and African American Children and Youth. Identified San Mateo County resident populations to be served by the program are:

- Severely Emotionally Disturbed (SED) and dually diagnosed children and youth (ages 6 to 21, including 16/17 old when it is developmentally appropriate and/or best meets the needs of the client and family) with multiple psychiatric emergency services episodes and/or frequent hospitalizations with extended stays.
- SED and dually diagnosed children and youth who are at risk of out-of-home placement or returning from residential placement, with juvenile justice or child welfare involvement.
- SED and dually diagnosed homeless children and youth / Transitional Aged Youth (TAY).
- Children and youth/TAY exiting school-based or IEP-driven services.
- Youth who are experiencing a "first break" and have been recently diagnosed with a psychotic disorder. This target population may or may not have had prior involvement with the mental health, juvenile justice, and/or child welfare systems.
- Youth and their family who are willing and able to participate in the treatment process.

Additionally, all enrollees in SAYFE are ages 6-18 years old; must be enrolled in, or at-risk of placement in an intensive school-based program (12 plus slots); or are currently being served in a Regional County clinic and are at-risk of out-of-home placement (12 plus slots).

Program Impact

SAYFE	FY 2021-22
Total clients served	68
Total cost per client	$15,978
Cost per contracted slot	$43,459

The SAYFE program utilizes the Wraparound model of care for children, youth, and families engaged in its program. The SAYFE program provides a variety of services to youths and her/his/them families. All treatment is voluntary, individualized, strengths-based, and actively engages the youth and family. These services may include, Family Therapy focuses on the care and management of client's mental health condition within the family system; Group Therapy with the client's goals for more than two or more family members that focus primarily on symptom reduction as a means to improve functional impairments; Collateral services provide support to one or more significant persons in the life of the client which may include consultation and training to assist in better utilization of services and understanding mental illness; and Rehabilitation Services assist in improving, maintaining or restoring functional skills, daily living skills, medication compliance, and access to support resources. The SAYFE program is unique because the team works alongside the BHRS Primary Clinician.

Also, the families and youths have access to Crisis Response Services provided by SAYFE program team, which is available twenty-four (24) hours on the weekends and after hours during the week. Families and youth also have access to Behavior Coaching Services, Psychiatry services, and/or external Therapeutic Behavioral Services (TBS) program.

Additionally, wraparound plans are more holistic than traditional care plans. They are designed to meet the identified needs of caregivers and siblings and address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop youth and family members' problem-solving skills, coping skills, and self-efficacy. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

Improves timely access and linkages for underserved populations:
The Youth FSP Programs works in collaboration with the other County Staff and contract to assure implementation of each enrollee's Care Plan. The Youth FSP Clinical Intake Coordinator contacts the referent party no later than five (5) business days following authorization by County Designated BHRS representative and opens the Admin Reporting Unit (RU) within 24 hours of receiving the referral from the Interagency Placement Review Committee (IPRC) team.

During the FY 2021-22, Edgewood FSP Programs participated in a Plan of Corrections to increase the Units of Services. Edgewood Youth FSP Programs successfully met the timely access and linkages expectations for FY 2020-21. The Youth FSP Programs created a system to better reflect "true numbers" and track all referrals/engagement before the current Management Information System (MIS) opening dates. The SAYFE Program completed the Units of Service requirements from the Plan of Correction. The Youth FSP programs are no longer in the Plan of Corrections.

The Youth FSP Programs current procedure when receiving a referral:

- The Youth FSP Clinical Intake Coordinator opens the Administrative RU when receiving the WSF and IPRC Form from the IPRC representative.
- The Youth FSP Clinical Intake Coordinator will contact the referent within five (5) businesses days within receiving notification from the IPRC representative.
- All (non-billable) services before “Treatment opening” will be captured in the “Administrative RU”.
- The Youth FSP Clinical Intake Coordinator will work with the referring party to obtain the referral packet as quickly as possible.
- Upon receiving the completed referral packet containing the necessary and sufficient information, the “Administrative RU” episode will be closed and then opened the “Treatment RU” episode.
- If the youth does not open in the “Treatment RU”, there will be documented efforts of attempts and rationale for not opening and the referring party will be informed throughout the process.
- The SAYFE Case Manager contacts the Primary Clinician for a provider’s meeting before contacting the family no later than five (5) business days from receiving the completed packet.
- The SAYFE treatment team contacts the family for initial intake no later than five (5) business days for commencement of treatment.

Reduces stigma and discrimination

The SAYFE program utilizes the Wraparound model of care for children, youth, and families engaged in its program. Wraparound is an intensive, holistic, evidence-based method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams. The wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that, when compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. The wraparound principle of voice and choice impacts the goals and interventions by including the perspectives of youth and family members during treatment. The care plan prioritizes the youth, the families, or other caregivers’ strengths and perspectives.

The SAYFE program has started providing Family Conferencing in the care planning process. The Family Conference is family-driven, strength-based, and promotes self-reliance. The Family

Conference is a process that brings together the youth, the family/caregiver, and their natural resources. The focus of the Family Conference is to explore Decision-Making and Problem-Solving for multi-needs families and develop an integrated and comprehensive plan for youth and their families/caregivers.

The SAYFE program is working on integrating more Family Conferencing in treatment to increase engagement and bring forward their voices and choices. The BHRS Oversight team will continue exploring the integration of Family Conferencing during the monthly meetings.

Increases number of individuals receiving public health services
The Youth FSP programs address the whole family and provide support to parents/caregivers when they have their mental health or substance abuse needs. The SAYFE Family Partners and SAYFE Case Managers facilitate access to services, interfacing with Adult Mental Health Services (MHS) or Alcohol and other Drug (AOD) services of BHRS. The SAYFE team will provide crisis/brief intervention services to those not meeting criteria and referring them to primary care or community resources, as needed.

The SAYFE's treatment team provides peer support and encouragement to the parents/caregivers to enhance the family's community and natural support, transportation services and supports as identified in the individualized action plan. The SAYFE Family Partners provide educational support to the parents/caregivers focusing on mental illness, co-occurring disorders, and finding resources.

Edgewood operates the only program in San Mateo County focused on kinship families- those in which youth are being raised by a relative caregiver independent of the foster care system. Kinship families present additional unique strengths and challenges. When TPCY serves kinship families, they are also connected to the Kinship Support Network to enhance the wrap-around services to include caregiver counseling, couple's counseling, community health nursing and case management, support groups, and respite.

Reduces disparities in access to care
In the Fiscal Year 2021-2022 and COVID-19 Shelter in Place, the Youth FSP Programs provided tools to the families in need to be able to access telehealth services. All the families were able to have access to equipment to participate regularly via telehealth. And the Youth FSP Programs provided alternatives to services: Telehealth or In-Person services since most of the families' work schedule had changed and needed flexibility for accessing services.

All programs under the umbrella of the Youth FSP are guided by a strong belief in:

- Service Integration: Communities are strengthened by a family-centered network of services and providers that partner with children, youth, and families and
- Local Focus: Children, youth, and families receive the highest quality of care when services are provided and accessible within their community.

Support for the Latino and Spanish Speaking Community: Several of BHRS partners, families, and bilingual/bicultural staff members highlighted challenges to providing culturally and linguistically matched services.

- The challenges:
    - There are limited community resources (and literature) in Spanish.
    - The SAYFE program has one bilingual Family Partner.
    - Cultural barriers may include being afraid to ask for assistance, issues with legal status, and/or personal beliefs regarding mental illness.
- The strategies:
    - During FY 2021-22, the Bilingual Clinician was promoted. The SAYFE continues to recruit Bilingual Clinician position.
    - The bilingual/bicultural treatment team members invest time and energy into explaining services, translating documents, and interpreting for meetings.
    - The SAYFE Bilingual Family Partners provide literature and resources in Spanish.
    - The Parenting Newsletter was in Spanish.
    - The Behavioral Health Director hired a Bilingual Clinical Intake Coordinator to provide support to monolinguals families during the orientation meetings.
    - The Bilingual/Bicultural Behavioral Health Director provides support and advocacy during providers' meetings to advocate for Spanish Speaking families.
    - In times where TPCY is unable to meet the language capacity for the monolingual's families, SAYFE uses Edgewood translation services.

Implements recovery principles
The Youth FSP, the SAYFE program utilizes the Wraparound Model of Care, which engages children, youth, and their families through four phases of treatment:

- Phase I (Discovery) - Engagement, assessment, stabilization, and planning
- Phase II (Hope) - Build skills and family connectedness
- Phase III (Renewal) - Strengthening and expanding formal and informal community support systems, affirm and support self-reliance strategies, prevent relapse, and leadership training
- Phase IV (Constancy) - Individualized aftercare planning to promote stability and permanence

The Youth FSP programs provide harm reduction, Stages of Change model for youth with co-occurring disorders. The SAYFE team will consult with the BHRS contractor where substance abuse is determined to be life-threatening and will implement more assertive interventions.

Successes

During the FY 2021-22, The BHRS Contract Managers extended the Plan of Correction to improve volume of services to all the FSP programs. The Youth FSP programs continue working closely with the BHRS oversight team in monthly and quarterly meetings to improve the volume of services requirements. TPCY successfully met all the goals, including the Units of Service requirements from the Plan of Correction. The Strategies used to maintain high documentation turnaround were the following:

- Provided staff documentation training in a quarterly basis to ensure staff is:
  - Up to date on medical documentation standards.
  - Appropriately capturing billable services (compared to non-billable services).
- Provide support to staff to be able for documentation to be done on time.
- Continued the system of support to motivate staff to document timely.
- Runs monthly efficiencies data to all staff in the Youth FSP Programs.
- A monthly incentive for high "Goal Getters."

Additional highlights from TPCY success:

- The SAYFE Program successfully met the Plan of Correction goals.
- During the FY 2021-22, SAYFE provided a hybrid model for the families.
- All Youth FSP Staff returning to in field/community work
- SAYFE was able to celebrate multiple celebrations such as "Mother's Day" by delivering packages to all the mothers in the program, Turkey Trot Gift Cards and Family Activity packages, and multiple successful graduations.
- The only Bilingual Family Partner has been able to serve families in SAYFE program.
- The SAYFE Case Managers have distributed items to families to encourage bonding and self-care (cooking together, spa day, and other activities), and have been working tirelessly to support the return to in-person school.
- The Youth FSP Leadership team build a system of support to increase the efficiencies of all the Youth FSP programs.
- Family Partner completed their yearlong weekly Peer Credential training
- Family Partner successfully completed Peer Certification 'Grandparenting' Application.
- Implementation of the new intake procedures in the Intake Department.
- Increased coordination with intake / program managers.
- The Care Coordinators and the Family Partner meet on a weekly basis.
- Youth Specialist Bonding-Activity Kits to the Youth FSP Families:
  - Created / delivered to family homes
  - Halloween
  - Dia de los Muertos / with education video
  - Camping Staycation
  - Self-care bingo
- Youth Specialist work on Donations for the Youth FSP programs:
  - Mother's Day Gift
  - High School Graduation gifts
  - Back to school supplies
  - COVID tests
- Youth Specialist Activities provided to all the Youth FSP Programs:
  - Summer Zoom Art Series (4 weeks)
  - Donuts with Dads
  - Father's Day
  - Galantines Day Event

    - Virtual Pride Month Event
    - Addition of Spanish language video interventions to complement the English language video interventions
- The Crisis Support Team successfully provided interventions via phone to all the FSP youth, families, and TAY.
- The Youth FSP Leadership team continued supporting the teams to increase the efficiencies of all the Youth FSP programs.

The following qualitative success stories highlight the work that the SAYFE Treatment Team (the Family Partner, the Case Manager, and the Family Therapist) provides. The SAYFE Treatment Team would usually work jointly with the External Primary Clinician, the Behavioral Coach Specialist, Psychiatrist Team, and/or external Therapeutic Behavioral Services (TBS) program.

Client Story #1: A 17-year-old male client was referred to the SAYFE Program due to severe anxiety and depression which impacted school attendance, social engagement, and overall interest in pleasurable activities. His mother has a long history of substance abuse, and although she has been in recovery, she struggles to manage her own mental health symptoms, especially in times of stress.

When client first started with the SAYFE Program, he had not attended high school for more than a few weeks (he had not gone to school for over 3 years). The only relationship he had with a trusted adult was with his therapist. The client and his mother engaged in family therapy, case management, and family partner services while in the program. Client began to trust the providers as he participated in services and was able to identify feelings related to his conflictual relationship with his mother, as well as personal goals for himself (obtaining a job, driver's license, high school graduation).

Furthermore, he was able to identify that he feels so behind in school, the thought of going and having to catch up was too overwhelming. He started to spend more time with his adult brother, who with the help of the SAYFE team, encouraged client to go to school for help with studying for the high school proficiency exam.

The client attended school almost every day to study, and he even developed friendships and romantic interests with peers. The case manager helped client to find a job, identify interests, and work toward his goal of living independently. Mother worked with the family partner and case manager to access community resources for financial support and focus on self-care to learn healthier strategies to manage her stress and overwhelm, as well as improve her relationship with her children.

After taking and passing the proficiency exam, client moved out of his mother's home and lives independently with his brother. He had a job, accessed his own community resources for food and mental health treatment, and reported that his relationship with his mother had improved since they no longer lived together, at the time the SAYFE team discharged him.

Client Story #2: A 14-year-old female client was referred to the SAYFE program due to significant symptoms of depression which impacted her ability to attend school and form

positive relationships with others. Client's mother struggled to support client's basic (physical and emotional) needs due to her significant trauma history. Mother would consistently report feelings of frustration, overwhelm, anger, and stress to the team regarding her life and client's behavior. Mother claimed she couldn't work because the client stressed her out so much with her behavior.

When client became upset or dysregulated, she would scream and yell disparaging remarks at mom. Mom shut down and became withdrawn from her daughter, leaving her to cope without support. Furthermore, client would refuse to go to school, report wanting to die, or plans to die, and mother did not know how to respond so she shut down and became unresponsive. Client had been hospitalized a few times prior and during her time in the SAYFE program. Mother called the crisis line frequently to ask them to talk to the client and "make her stop" or "take her to the hospital". She lacked basic parenting skills and would rely on providers to parent for her. The family clinician, behavior coach, case manager, and family partner worked closely with this family to support them with basic needs, parenting and communication skills, and psychoeducation.

It was difficult to engage this mother in treatment initially because she reported being "too busy for meetings and to care for myself". The team did not give up and continued to encourage the mother to support her daughter with her mental health symptoms and explained the importance of doing so.

After nearly 18 months of minimal engagement and follow through with the team, client began to attend school, discuss her feelings related to her family relationships, and ask for support to complete tasks she knew were hard for her mother to support with (talking to teachers, looking for school resources, talking to providers).

At the time of discharge, client has an individual education plan that helps to improve her school attendance and achievement, her engagement in therapy increased, hospitalizations decreased, and she is able to advocate for her needs. Not only has the mother agreed to seek her own support from an individual therapist, but she is also waiting for a provider to be assigned to her. The family partner called the ACCESS line with the mother and supported her through the process.

During the discharge meeting, the mother stated that she knows that she "did not use all the services and support" and she admitted that "things were too overwhelming for me I didn't know where to start and I should have asked for more help. I don't want my daughter to give up on her life. I know to ask for help now and I need to get my own support."

Client Story #3: Jason was referred to wrap around services in September of 2020. He was opened to behavioral coaching services in November of 2020. At the time, the client was a 7-year-old who lived with his mother, her boyfriend, and younger sister. The client had recently been reunified with his mother from being in a foster placement for several months. The client had a history of engaging in aggressive and defiant behaviors in all settings. The client became easily triggered by his younger sister touching his things as well as when limits were being set

for him. Aggressive behaviors included kicking, hitting, spitting, pushing, and/or expresses desire to hurt himself such as “I want to die”, when he did not get what he wants. The client engaged in these behaviors toward his mother and younger sister. The client engaged in negative self-talk such as “I am bad” and “nobody cares about me”. The client also engaged in tantrum behaviors in the form of yelling, screaming, and whining when he did not get his way. The client had a difficult time being redirected and focusing on specific tasks. In the school setting, the client would engage in behaviors including talking back, not following directions and throwing items at others.

Jason and his mother met weekly with the treatment team to address behaviors impacting his functioning. Throughout treatment, the client utilized breathing exercises in the home, school and in session with writer. The client was able to take space away from most triggering situations when needed in order to avoid engagement in behaviors. The client showed ability to identify feelings in his body when upset as a warning sign before engagement in behaviors occur. The client was able to identify and verbalize both positive and negative emotions to writer during session, at home to his mother and while at school to his teachers and 1:1 aid. When feeling upset, the client was able to utilize replacement behaviors and activities with support from his mother, including art projects, listening to music or playing outside to release energy. The client showed ability to understand why various behaviors were impacting his relationships with others. The client also spent time learning about various communication styles to support in improving his pro-social skills.

Jason’s mother was able to develop and utilize co-regulation tools to support the client in managing behaviors in the home. The client’s mother developed a structured weekly routine with the client that supported him in boundary setting and understanding the purpose of limit setting. The client’s mother became his number one advocate, using her voice to express the needs for her son. The client’s mother was able to implement reward/consequence system in the home for the client. The client’s mother was able to utilize appropriate consequences in the home to support in reducing behaviors in all settings. The client’s mother often used screen time as a reward and consequence which was effective for the client.

Behavioral coaching services moved towards closing as a result of the client having successfully made progress within the last 8 weeks of treatment, reducing his engagement in target behaviors and displaying the ability to utilize interventions and tools learned in treatment with support from his mother, and at times on his own. The client had shown the ability to identify and express his feelings when in triggering situations while also identifying what he needs in those situations to deescalate and not engage in behaviors.

The client was able to graduate from behavioral coaching services in April of 2022 as a result of progress made towards his treatment goals. The client and his mother showed great success with wrap around and behavioral coaching services.

*The name and some identifying factors have been changed to protect the youth’s identity. Quantitative data were provided through the submission of documentation to the state database and unfortunately, do not receive the aggregate results of these data.

Challenges

There were a handful of challenges during the previous FY 2020-21, which followed through FY 2021-22. COVID-19 Shelter in place was extended mid-fiscal year. While ongoing challenges around the increasing cost of living and lack of qualified candidates to fill open positions continues to be addressed, the SAYFE program maintained a full census. These challenges, their impact, and possible solutions are highlighted below:

Cost of living in the Peninsula and consistent staffing: The high cost of living continues to present a challenge for the families (and staff) who are unable to locate affordable and suitable housing. The COVID-19 Shelter in Place and closure of business brought the loss of salary to some families. The SAYFE program continued to struggle to recruit and retain some staffs who were qualified (e.g., had the language capacity, lived experience, or necessary credentials) to adequately treat the families served.

- The challenges:
  - Families are frequently living in households with multiple members, impacting quality of life, privacy, and safety.
  - During the pandemic, the low-economic households were having difficulties with WiFi.
  - Families experienced several provider changes, as different members of their treatment team transitioned to/from the team.
  - Due to Shelter in Place, access to previous benefits were not available, such as Food Pantry.
  - Edgewood's salary rates do not match the astronomical cost of living in the county. This is not unique to Edgewood.
- The strategies:
  - County is working to create more affordable housing and increase living wages.
  - Edgewood got COVID-19 grants continued to be able to provide resources to families in need of food, equipment, and any other immediate need.
  - As providers of community-based services, staff provided hybrid services: face to face and telehealth due to COVID-19 precautions.
  - As a Trauma-Informed System (TIS) agency, Youth FSP encourages and attempts to incorporate self-care regularly to avoid burnout.
  - In times where SAYFE was unable to meet the language capacity of a family (e.g., Spanish), SAYFE used Edgewood translation services.

COMPREHENSIVE FSP "TURNING POINT"

Part of the Youth Full-Service Partnership (FSP), Turning Point Child and Youth (TPCY) Program is designed to support the county's most vulnerable youth and their families to maintain and improve the youth's placement. In congruence with Edgewood Center's mission and values, the Full-Service Partnership (FSP) work is informed by a core belief that children, youth, and

families are best served and supported in the context of their unique family system, culture, and community.

The Turning Point Child and Youth (TPCY) Program is a comprehensive program for 40 of the highest risk children/youth living in San Mateo County. TPCY is designed to help children and youth achieve independence, stability, and wellness within the context of their culture, community, and family.

Youths are primarily referred to the TPCY program through Human Services Agency (HSA – child welfare), Juvenile Probation, San Mateo County Clinics, and Schools (typically with an IEP for emotional disturbance). The treatment is provided to help stabilize youth in their home environment and prevent (or transition back from) a higher level of care (e.g., psychiatric hospital, residential facility, juvenile hall, etc.). All programs under the umbrella of the Youth FSP are guided by a strong belief in:

1. Service Integration: Communities are strengthened by a family-centered network of services and providers that partner with children, youth, and families and
2. Local Focus: Children, youth, and families receive the highest quality of care when services are provided and accessible within their community.

The Youth Full-Service Partnership (FSP) Program services are open to all youth meeting the population criteria below. However, it is specifically targeted to Asian/Pacific Islander, Latino, and African American Children and Youth. Identified San Mateo County resident populations to be served by the program are:

- Severely Emotionally Disturbed (SED) and dually diagnosed children and youth (ages 6 to 21), including 16/17 old when it is developmentally appropriate and/or best meets the needs of the client and family) with multiple psychiatric emergency services episodes and/or frequent hospitalizations with extended stays.
- SED and dually diagnosed children and youth who are at risk of out-of-home placement or returning from residential placement, with juvenile justice or child welfare involvement.
- SED and dually diagnosed homeless children and youth / Transitional Aged Youth (TAY).
- Children and youth / TAY exiting school-based or IEP-driven services.
- Youth who are experiencing a "first break" and have been recently diagnosed with a psychotic disorder. This target population may or may not have had prior involvement with the mental health, juvenile justice, and/or child welfare systems.
- Youth and their family who are willing and able to participate in the treatment process.

Additionally, all enrollees in C/Y:

- Are ages 6-21 years old.
- Are at risk for placement in a level 10-14 residential facility or "stepping down" from a level 10-14 residential facility: and
- Must be currently involved in Child and Family Services (Child Welfare) or Probation.

The TPCY program utilizes the Wraparound model of care for children, youth, and families engaged in its program. In the Youth FSP, the TPCY program provides various services to youths and their families. All treatment is voluntary, individualized, strengths-based, and actively engages the youth and family. These services may include: individual therapy with the client's goals that focus primarily on symptom reduction as a meant to improve functional impairments; Group Therapy with the client's goals for more than two or more family members that focus mainly on symptom reduction as a means to improve functional impairments; Family Therapy focuses on the care and management of client's mental health condition within the family system; Collateral services provide support to one or more significant persons in the life of the client which may include consultation and training to assist in better utilization of services and understanding mental illness; and Rehabilitation Services assist in improving, maintaining or restoring functional skills, daily living skills, medication compliance, and access to support resources.

Also, the families and youths have access to the Crisis Response Services provided by the Youth FSP team, which is available twenty-four (24) hours on the weekends and evenings. Families and youth also have access to Behavior Coaching Services and Psychiatry services.

Additionally, wraparound plans are more holistic than traditional care plans. They are designed to meet the identified needs of caregivers and siblings and address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop youth and family members' problem-solving skills, coping skills, and self-efficacy. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

Program Impact

Comprehensive FSP	FY 2021-22
Total clients served	110
Total cost per client	$25,843
Cost per contracted slot	$63,318

The Youth FSP Programs works in collaboration with the other County Staff and contract to assure implementation of each enrollee's Care Plan. The Youth FSP Clinical Intake Coordinator contacts the referent party no later than five (5) business days following authorization by County Designated BHRS representative and opens the Admin Reporting Unit (RU) within 24 hours of receiving the referral from the Interagency Placement Review Committee (IPRC) team. During the FY 2021-22, Edgewood FSP Programs participated in a Plan of Corrections to improve timely access and linkages and increase the Units of Services. Edgewood Youth FSP Programs successfully met the convenient access and linkages expectations for FY 2021-22.

The Youth FSP Programs created a system to reflect better "true numbers" and track all referrals/engagement before the current MIS opening dates. The TPCY Program completed the Units of Service requirements from the Plan of Correction.

- The Youth FSP Clinical Intake Coordinator will contact the referent within five (5) businesses within receiving notification from the Interagency Placement IPRC representative.
- All (non-billable) services before “Treatment opening” will be captured in the “Administrative RU”.
- The Youth FSP Clinical Intake Coordinator will work with the referring party to obtain the referral packet as quickly as possible.
- Upon receiving the referral packet containing the necessary and sufficient information, the “Administrative RU” episode will be closed and opened as a “Treatment RU” episode.
- If the youth does not open in the “Treatment RU”, there will be documented efforts of attempts and rationale for not opening.
- The TPCY Care Coordinator contacts the family for initial intake no later than five (5) business days for commencement of treatment.

Reduces stigma and discrimination
The TPCY utilizes the Wraparound model of care for children, youth, and families engaged in its program. Wraparound is an intensive, holistic, evidence-based method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams. The wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that, when compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. The wraparound principle of voice and choice impacts the goals and interventions by including the perspectives of youth and family members during treatment. The care plan prioritizes the youth, the families, or other caregivers’ strengths and perspectives.

In addition, TPCY provides Family Conferencing in the care planning process. The Family Conference is family-driven, strength-based, and promotes self-reliance. The Family Conference is a process that brings together the youth, the family/caregiver, and their natural resources. The focus of the Family Conference is to explore Decision-Making and Problem-Solving for multi-needs families and develop an integrated and comprehensive plan for youth and their families/caregivers. During the FY 2021-22, During the shelter in place, The COVID-19 Pandemic influenced how the Family Conference was delivered. For most of the time, the families and youth were able to utilize the telehealth meetings. The family and the youth preferred telehealth Family Conferencing and were done successfully. The TPCY treatment team offers the option to have telehealth meeting or in-person Family conferencing.

Increases number of individuals receiving public health services
The Youth FSP programs address the whole family and support parents/caregivers when they have their mental health or substance use needs. During the previous FY 2020-21, the nation experienced the COVID-19 Pandemic. The TPCY Family Partners, Clinicians, and Care Coordinators facilitated access to services via telehealth. The Youth FSP Programs advocated and assessed equipment needs (i.e., Laptops, Wi-Fi, etc.) to ensure all families had access to the Telehealth services. The TPCY Family Partners and Case Managers facilitate access to services, interfacing with Adult Mental Health Services (MHS) or Alcohol and other Drug Services (AOD) of the BHRS Division. The TPCY team will provide crisis/brief intervention services to those not meeting criteria and refer them to primary care or community resources, as needed.

The TPCY's treatment team provides peer support and encouragement to the parents/caregivers to enhance the family's community and natural support, transportation services. It supports identified in the individualized action plan. The TPCY Family Partners provide educational support focusing on mental illness, co-occurring disorders, and finding resources. During COVID-19 Shelter in Place, the Family Partners have been instrumental in sending the resources and information via mail and email.

Edgewood operates the only program in San Mateo County focused on kinship families- those in which youth are being raised by a relative caregiver independent of the foster care system. Kinship families present additional unique strengths and challenges. When TPCY serves kinship families, connection to the Kinship Support Network enhances the wrap-around services, including caregiver counseling, couple's counseling, community health nursing and case management, support groups, and respite.

Reduces disparities in access to care
In the Fiscal Year 2021-2022 and COVID-19 Shelter in Place, the Youth FSP Programs provided tools to the families in need to be able to access telehealth services. All the families were able to have access to equipment to participate regularly via telehealth. And the Youth FSP Programs provided alternatives to services: Telehealth or In-Person services since families' work schedule had changed and needed flexibility for accessing services.

All programs under the umbrella of the Youth FSP are guided by a strong belief in:

- Service Integration: Communities are strengthened by a family-centered network of services and providers that partner with children, youth, and families and
- Local Focus: Children, youth, and families receive the highest quality of care when services are provided and accessible within their community.

Implements recovery principles
The Youth FSP, TPCY program utilizes the Wraparound Model of Care, which engages children, youth, and their families through four phases of treatment:

- Phase I (Discovery) - Engagement, assessment, stabilization, and planning
- Phase II (Hope) - Build skills and family connectedness

- Phase III (Renewal) - Strengthening and expanding formal and informal community support systems, affirm and support self-reliance strategies, prevent relapse, and leadership training
- Phase IV (Constancy) - Individualized aftercare planning to promote stability and permanence

The Youth FSP programs provide harm reduction, Stages of Change model for youth with co-occurring disorders. TPCY team will consult with the BHRS contractor where substance use is determined to be life-threatening and will implement more assertive interventions.

Successes

During the FY 2021-22, The BHRS Contract Mangers extended the Plan of Correction to improve volume of services to all the FSP programs. The Youth FSP programs continue working closely with the BHRS oversight team in monthly and quarterly meetings to improve the volume of services requirements. TPCY Successfully met all the goals, including the Units of Service requirements from the Plan of Correction. The census was increased to 45 total.

Strategies to maintain high documentation strategies:

- Provided staff documentation training in a quarterly basis to ensure staff is:
  - Up to date on medical documentation standards.
  - Appropriately capturing billable services (compared to non-billable services).
- Provide support to staff to be able for documentation to be done on time.
- Continued the system of support to motivate staff to document timely.
- Runs monthly efficiencies data to all staff in the Youth FSP Programs.
- A monthly incentive for high “Goal Getters.”

Here are some highlights from TPCY:

- The TPCY program successfully met the Plan of Corrections goals.
- TPCY filled the bilingual clinician positions and the Clinical Program Manager position.
- Coverage of all TPCY families by Two Bilingual Family Partners
- TPCY provided the Winter holiday donation on drive.
  - Gift delivery to families for the Holidays
- Family Partners completed their yearlong weekly Peer Credential training
- Family Partners successfully completing Peer Certification ‘Grandparenting’ Process
- The Youth Specialist program created Video interventions of youth specialists:
  - ‘Checking in with Alex and Rossy’
- All Youth FSP Staff returning to in field/community work
- Increase in family conferencing across teams
- Implementation of the new intake procedures in the Intake Department
- Increased coordination with intake / program managers.
- Addition of Clinical Program Manager – Dr. Kate Hellenga, PhD.

- Manager retreat and planning day – Kate Hellenga and Billy Brimmer
- Revision of staff meeting plan – one focus for staff training in Pod meetings each week
    - Documentation Training and improvement to all TPCY staff
    - TIS Principles: Building skills with staff
    - Case Consultation
    - Wellness and Recovery trainings
    - Wraparound Principles Training
- Care coordinator trainings
- Care Coordinator Workgroup process
- Back to school support by the family partners
- Better training and procedure on Crisis Line requests
- New Program Manager, Renee Rodriguez, for Crisis Response Team and Behavior Coach Support Team.
    - Streamlined process for TBS referrals and BXC at Intake
- More efficient referrals to Psychiatry at Intake
- Increase in partnership with Crisis line staff / increase in nightly check in calls to youth/families
- Youth Specialists working projects to include the entire youth FSP – SAYFE and TPCY
- Youth Specialist Bonding-Activity Kits to the Youth FSP families:
    - created / delivered to family homes
    - Halloween
    - Dia de los Muertos / with educational video
    - Camping Staycation
    - Self-care bingo
- Youth Specialist work on Donations for the Youth FSP families:
    - Mother's Day Gift
    - HS Graduation gifts
    - Back to school supplies
    - COVID tests
- Youth Specialist Activities
    - Summer Zoom Art Series (4 weeks)
    - Donuts with Dads
    - Father's Day
    - Galantines Day Event
    - Virtual Pride Month Event
    - Addition of Spanish Language video interventions to complement the English language video interventions
- Youth Specialist Video interventions
    - Father's Day
    - Mother's Day
    - Internet Safety Tips

    - New Year's Resolutions and Mental Health
    - Embracing change in the Fall
    - Back to School and Mental Health
    - Finding Mental Health in Nature
- The Crisis Support Team successfully provided interventions via phone to all the FSP youth, families, and TAY.
- The Youth FSP Leadership team continued supporting the teams to increase the efficiencies of all the Youth FSP programs.

The following qualitative success stories highlight the work that the TPCY Treatment Team (the Family Partner, the Care Coordinator, the Clinician, and/or the Youth Specialist) provides: The TPCY Treatment Team would usually work jointly with the Behavioral Coaching Specialist, Psychiatrist Team, and/or external Therapeutic Behavioral Services (TBS)

program.

Client Story # 1: Client was referred to behavior coaching July 7th, 2021. Client had been open in service with Turning Point since September 29, 2020, shortly after stepping down from a placement at Canyon Oaks. Prior to placement, client had multiple psychiatric hospitalizations. Of note, this is the second time client was receiving services with Edgewood. Client was referred for Behavior Coach Services to work on specific behaviors around completing homework, learning to manage his reaction when he is given an unpreferred task, and how to handle his emotions when "being made fun of."

When services started, client shared his frustration with needing to "go to work with my dad." His relationship with dad was strained and client felt unsupported. Father was only involved in services on a limited basis; however, his mother was completely invested in services.

While on service, client faced many struggles at home, and at school. Over time, client was learning techniques to self-regulate, and could say out loud what coping skill he was using. Suddenly, a quite different young man was emerging. In the beginning of services, Client would attend family conferences, however, he would rarely, if ever, appear on camera. He would yell comments, often laced with profanity. He would not answer questions, never had an agenda item to discuss.

Somewhere during services, Client began to advocate for his needs. He requested that his behavior coach not visit him at school, but to meet elsewhere. This request was honored, and meetings were held either via zoom or in person. Client was not only attending family conferences, but he would also appear on camera, was polite and engaged in the meeting.

Client began to have symptoms that he did not understand, and after researching online, he advocated for a discussion with his psychiatrist to confirm his findings. His psychiatrist provided diagnosis, and related symptoms. This was the first time Client verbally acknowledged his

diagnosis. He accepted the psychoeducation provided and was determined to learn to manage his symptoms to improve his quality of life.

Client had an issue at school which required his parents attending a meeting on campus. I was present for this meeting, with Client, and both parents present. It was a disciplinary meeting, and after the school administrator presented the situation Client was involved in, Father mentioned that Client has “mental health issues” and that it can be a barrier. Client was able to speak up and acknowledge his mental health issues, but also stated that he is working hard in treatment to learn how to better respond to difficult situations. The school administrator openly acknowledged all the positive changes Client has made and continues to make.

Client also utilized his newly found skills to build a relationship with his father, which has always been strained. Client was involved in an incident at school. Mother was worried because father had been contacted, and she feared a verbal altercation would arise. Mother was pleasantly surprised that CLIENT requested the school contact father regarding the situation. Mother was ecstatic that Client was not only including father, but having father take the lead!

Client had sought out information, acquired paperwork, and enrolled in the wrestling team at school, on his own with no support. This was a huge step for Client, and the team showered him with praise. Client started to pull back from the behavior coach around this time. He would offer vague reasons as why he couldn’t meet, or that he had wrestling practice. After further conversation with his mother, mother agreed to have a discussion with Client and stated she would wait for the right time to discuss. Services were put on pause at this time.

Mother got back to the program and shared that client was ready to end services with behavior coaching. Client felt that he had learned all that he could and was applying those skills in his everyday life. Client was now feeling like a burden to the behavior coach and thought the coach’s time could be better utilized with another youth.

During the IEP, mother was requesting summer school for client and additional support services. School denied need for summer school and shared that not only was Client on track academically and therefore did not qualify for summer school, but the school also noted a huge improvement in social situations, a decrease in disruptive behaviors, and noted Client was more outgoing and making positive connections with classmates and staff.

The team met to discuss Client’s request to stop behavior coaching and came to an agreement he has not only filled his toolbox, but he had also successfully demonstrated how to utilize the tools he has learned. Behavior coaching services closed, June 2022 and client continue with his wraparound team.

Client Story #2: Victor is a cisgender Latinx boy who lives with his mother and younger sibling. Victor and his family had previously lived with mother’s partner, who was violent toward her and her children. Victor was both a witness and a victim of this violence. He was referred to

Turning Point C/Y at age nine, because he was frequently overwhelmed by his emotions, and when this happened, he resorted to physical and verbal aggression, including foul and abusive language, threats of harm, breaking objects, and kicking, hitting or biting other people. These episodes resulted in frequent calls to the police, whose presence was temporarily helpful but could not address the underlying causes of the problem.

When the family agreed to work with Turning Point C/Y, the treatment team supported them to develop an initial Safety Plan, identifying strategies to mitigate harm and de-escalate situations, and encouraging the family to contact Edgewood's Crisis Response Team (CRT) when they could see a crisis developing, or when it was already in process. When treatment began, Victor's mother called the CRT almost nightly. Both mother and Victor received coaching and support by phone from the CRT, who would then share information about the incident with the rest of the treatment team.

After developing the family Plan of Care and the clinical Treatment Plan, the team began providing services and identifying additional needed supports. They referred Victor to a partner agency for TBS, with a primary goal of Victor and his family to develop a morning routine for getting Victor to school without emotional or behavioral "blow-ups." Victor also had an individual therapist at school. The Care Coordinator connected the TPCY team with the TBS provider and the school therapist, to align treatment goals and improve the synergy across services. Because Victor had an individual therapist, the TPCY Clinician emphasized dyadic family therapy with mother and Victor, and collateral support for mother.

Family therapy initially focused on increasing Victor's tolerance for the sessions. When they started work together, Victor would begin to get agitated, with escalating emotions, after just 5-10 minutes. The Clinician provided Victor with education and preparation about some of the likely topics the sessions would focus on, like self-awareness, communication skills, and coping with feelings. She facilitated quick art activities that could engage client without him becoming overstimulated, and supported Victor and his mother to learn and practice coping, mindfulness and grounding exercises to maintain calm and increase tolerance for stressful situations. Over time, Victor was able not only to stay longer in family therapy sessions, but to improve his communication with his mother, telling her directly about his feelings and needs. At the same time, the clinician was providing collateral support to mother, with psychoeducation about trauma responses and emotional dysregulation, and coaching about how to stay calm and grounded when Victor's behavior is escalating.

The team also made a referral to the Edgewood's Behavior Coaching (BC) team, to provide in-home support and coaching for Victor to help him recognize his feelings, learn to express them appropriately, cope with difficult events and accept that mother would consistently impose consequences for misbehavior. As these planned, coordinated interventions began to have their effects, the family's calls to the CRT declined from 5-7/week to 2-3/month. Victor is more

aware of his feelings and impulses and is able to give warnings that he is beginning to be upset. Instead of threatening or doing harm, he can honestly say, “I feel like punching you but I’m not going to.” And when he cannot contain the impulse completely, he is able to express it in ways that keep himself and others safe. At the same time, with coaching from the Clinician, Behavior Coach and the CRT staff, Victor’s mother has developed confidence and gained new skills in managing and supporting Victor when his emotions become overwhelming and lead to challenging behavior.

Victor’s view of himself seems to be changing. The team clinician recalls that early on, he would express the view that he “will be a criminal” someday and imply that he was “unlovable.” While he continues to have difficulty tolerating praise and affection, which challenge his old beliefs too directly, he has begun to express the possibility of a positive future for himself. He has begun to share stories of past traumas with his Behavior Coach and Clinician, but he is also able to set boundaries for himself: “I’m not ready to talk to you about that.” And as pandemic restrictions eased, he was able to say to his Clinician, “I feel happy when you come see me in person,” and to continue the session calmly, without becoming overwhelmed.

As a strengths-based program, successes are identified daily, not just at graduation. Victor and his mother are absolutely a success story, and TPCY is happy to continue supporting them as they move toward their Plan of Care goals. They have worked hard and bravely to engage in crucial conversations, to look at their own feelings and behavior, and to move toward a better future they could not completely imagine for themselves. TPCY is honored by their trust in the program and proud of the changes they continue to make.

Client Story #3: Arturo is a 16-year-old boy, identifying as heterosexual with origins from Mexico and Guatemala. He lives with his mother and father and two siblings in San Mateo County. Arturo is a 10th grader currently involved in mainstream classes at his local public high school. His father is a landscaper and originally from Mexico. His mother is a housewife and caretaker of the children and originally from Guatemala. The parents are primarily Spanish-speaking.

At the time of referral, the school district was requesting wraparound services as the youth was stepping down from a residential care facility in county. He needed ongoing medication support. It was identified that Arturo needed to learn self-regulation skills. It was also noted that it was very difficult to engage the father in services. Family support was requested. It was noted that the youth had some improvement with anger management skills in treatment but had ongoing conflict and a difficult relationship with his father who was reported to be emotionally abusive. At the time of referral there was an autism evaluation pending and the mother was seeing a therapist of her own.

At the beginning of treatment Arturo expressed his desire to blend in more with his family and work and communicate better with his parents. The parents and particularly the father demonstrated and need to work on their understanding of the developmental and mental health issues and learn a new language of support to replace the blaming and shaming communications that had been present in the family previously.

Initially the father was rather challenging to engage in treatment due to his level of interest and the practical challenges with his work schedule. Mother was very interested and had a more flexible schedule, she was easier to engage in services and support meetings. The father presented as often being angry with the Arturo's behavior. Arturo stated he was concerned, and sometimes scared, to communicate directly with his father. He had great difficulty requesting boundaries around his afterschool schedule and wanting to spend more time on his homework rather than working with his father.

Also, during treatment this youth and family experienced stresses due to the COVID pandemic. This had the result of making Arturo 's father busier at work with less time to spend at home and less patience with Arturo and the family. Arturo's mother had more responsibilities at home supporting all three of the children with their schoolwork. Arturo and his siblings were having much less contact with their friends and classmates and experienced increased isolation and sadness. Developmentally, Arturo is a teenager and has an increased drive to connect socially with his peers and romantic interests. Due to the pandemic his social contacts were quite limited, and ultimately this impacted his affect and behavior quite negatively.

During the family's involvement with the wraparound program, they benefited greatly from many of the services provided and offered to families. Arturo's family got support with his IEP meetings and in preparing for IEPs. Arturo engaged in individual therapy weekly. The family engaged in family therapy sessions on a weekly basis. A behavior coach was assigned meet with Arturo individually to complement the work done in the therapeutic meetings. Arturo's behavior coach ended up being quite a special connection for him. The behavior coach was also male identifying and was a linguistic match for the family who primarily speak Spanish. Arturo bonded quite well with his behavior coach and truly benefited from both the practical skills support as well as the motivational work and encouragement that the behavior coach provided on a weekly basis. The family also engaged in monthly family conferences with the full wraparound team planning for Arturo's needs and the needs of his family. The family conferences were run and conducted by a trained facilitator outside of the treatment team. Psychiatry services were provided to Arturo to assist with medication, prescriptions, medication management, and psychoeducation regarding mood and behavioral concerns. Arturo's treatment team used flex funds to provide incentives, food during family conferences snacks in individual treatment meetings, and recreational interests such as paying for Arturo to attend a boxing class that he enjoyed very much during his time in the wraparound program.

During the pandemic the family was learning like many other families across the country and world how to navigate these challenges. One of the things that Arturo‘s parents did was to allow him to move into a room of his own and decorate it giving him a bit of purpose, more of a sense of independence and more privacy. This was a positive move made by his family. Additionally, the parents learned in conversation with the treating providers, that animals may be a positive way to fill the void left by the loss of social connections. Ultimately the family adopted both a dog and a cat to help the children through this difficult time.

A focus and service provided by the wraparound team was also to support Arturo’s parents on finding new strategies to help him and ways to communicate with him that would feel more supportive. Collateral sessions were provided by the clinician, the psychiatrist, and weekly by the family partner. The family partner developed a very unique, supportive connection with both the mother and the father in individual and group meetings throughout Arturo‘s time in the wraparound program. The family partner supported the father in learning how to communicate more gently and warmly with Arturo. Family partner also worked with Arturo‘s father to assist him with developing his expectations of Arturo given his mental health and developmental limitation‘s. The father engages the family partner in deep discussions regarding his early childhood experiences. He was able to make connections regarding his own challenges and how that may at times be projected on his son.

Arturo changed and flourish during his time with the wraparound program. He learned to speak up and participate more in meetings and family conferences even though he is naturally quiet. Arturo stated he wanted to better himself and was able to overcome much stigma about mental health. And his process of working with the clinician and the behavior coach and psychiatrist he stated he came to trust himself more during the process. The mother engaged regularly with the family partner and learned how she could best navigate challenges in the family dynamic and be a best coparent with her husband while also at times seeing things differently than he did. Mother benefited from resources and education regarding community supports available during her weekly meetings with the family partner. Mother engaged in regular problem-solving and learning more about the particular unique ways she can help her son navigate his emotional and functional challenges.

There are many clear achievements the youth and family made during their time in treatment with the wraparound program. The mother gained specific knowledge around developmental concerns and coping skills. Both of the parents have reported increases in their patience and understanding of Arturo‘s mental health and developmental needs. The father is more verbally expressive of his love for Arturo at this time. The father has also Come to a level of acceptance that the youth needs, to focus more on school and homework rather than working alongside his father on landscaping jobs. This was a major family concern during treatment that the parents had conflict over.

Another major marker of success is that the youth had the intention of decreasing and then stopping his use of medications. He was able to successfully work with his family and psychiatrist to lower his medication's to the point of not needing them. He replaced the medications with increased coping skills and support from his family and was fully able to end his need for psychiatric treatment. He is no longer on medications at this time. The psychiatrist was instrumental in achieving the success and truly tailored his interventions to suit the family culture and utilized his special connection with the youth to encourage him and motivate him. This important work between the youth and psychiatrist is the main reason the youth was so successful in wraparound treatment.

Finally, the youth is also demonstrating an increased level of participation at school. This resulted in advocacy for the youth to be mainstreamed again in classes at his public high school. This was his intention and personal goal to return to mainstream classes. He was able to achieve that with the support of his family and treatment team during the wraparound treatment. He is achieving better grades, he is more successful at school, and has no major concerning behavior with peers. The school team is fully in support of this youth graduating from the wraparound program. He is currently also participating in extracurricular activities including wrestling at school. This is a wonderful success story for the program.

*The name and some identifying factors have been changed to protect the youth's identity. Quantitative data were provided through the submission of documentation to the state database and unfortunately do not receive the aggregate results of these data.

Challenges

There were a handful of challenges during the previous FY 2020-21 which followed through FY 2021-22. COVID-19 Shelter in place was extended mid-fiscal year. While TPCY continues to assess and address ongoing challenges around the ever-increasing cost of living and lack of qualified candidates to fill open positions, TPCY was able to fill the bilingual clinician position and the Clinical Program Manager position.

These challenges, their impact, and possible solutions are highlighted below:

<u>Support for the Latino and Spanish Speaking Community</u>:
Several BHRS partners, families, and bilingual/bicultural staff members highlighted challenges to providing culturally and linguistically matched services.

- The challenges:
    - Some monolingual's families reported having difficulties with utilizing telehealth and having interpreters in the zoom meetings.
    - Cultural barriers may include being afraid to ask for assistance, issues with legal status, and/or personal beliefs regarding mental illness.
    - One of the TPCY bilingual clinician positions is still vacant. This position is hard to fill.

- The strategies:
    - Increase recruitment of bilingual/bicultural direct line staff to provide services to monolingual Spanish Speaking families.
    - The Behavioral Health Director hired a Bilingual Clinical Intake Coordinator to provide support to monolinguals families during the orientation meetings.
    - Bilingual/bicultural treatment team members invest time and energy into explaining services, translating documents, and interpreting for meetings.
    - The Family Partners provide literature and resources in Spanish to the families.
    - The program hired a bilingual Youth Specialist to provide services to Latino/Hispanic families.
    - The bilingual/Bicultural Behavioral Health Director provides support and advocacy during providers' meetings to advocate for Spanish Speaking families in the system.
    - In times where TPCY is unable to meet the language capacity for the monolingual's families, TPCY uses Edgewood translation services.

<u>Cost of living in the Peninsula and consistent staffing:</u>

The high cost of living continues to be a present challenge for families (and staff) who are unable to locate affordable and suitable housing. The COVID-19 Shelter in Place and closure of business brought the loss of salary to some families. The TPCY program continued to struggle to recruit and retain staff who were qualified (e.g., had the language capacity, lived experience, or necessary credentials) to adequately treat the families that the program serves.

- <u>The challenges</u>:
    - Families are frequently living in households with multiple members, impacting quality of life, privacy, and safety.
    - During the pandemic, the low-economic households were having difficulties with getting WiFi accessible.
    - Families experienced several provider changes, as different members of their treatment team transitioned to/from the team.
    - Due to Shelter in Place, access to previous benefits, such as Food Pantry, was not available.
    - Edgewood's salary rates do not match the astronomical cost of living in the county. This is not unique to Edgewood.
    - Staff are unable to afford to live in the county, this has resulted in them moving out of the county, which has resulted in a turnover in the TPCY program for this reporting period.

- <u>The strategies</u>:
    - County is working to create more affordable housing and increase living wages.
    - Edgewood got COVID-19 grants continued to be able to provide resources to families in need of food, equipment, and any other immediate need.

- As providers of community-based services, staff provided hybrid services: face to face and telehealth due to COVID-19 precautions.
- When families relocate to other counties, staff work with them to ensure that there are resources in place before their move, to ensure continuity of care.
- As a Trauma-Informed System (TIS) agency, Youth FSP encourages and attempts to incorporate self-care regularly to avoid burnout.
- In times where TPCY was unable to meet the language capacity of a family (e.g., Spanish), TPCY used Edgewood translation services.

OUT-OF-COUNTY FOSTER CARE SETTINGS FSP

Through the collaborative relationship between San Mateo County and Fred Finch Youth and Family Services (FF), the East Bay Wraparound (EBW) formed a Full-Service Partnership (FSP) in 2010. The EBW-FSP program provides a full spectrum of community-based services to enable participants to achieve their identified goals. FF provides a wraparound services model to promote wellness, self-sufficiency, and self-care/healing to 10 San Mateo County Court dependents (foster youth) who currently live outside of the county. When foster youth live outside of their court-dependent county, they often have difficulty accessing mental health services. The wraparound model helps provide intensive community-based care rooted in a strength-based approach. The youth and family receive individualized services to maximize their capacity to meet their child's needs and reduce the need for residential placement.

EBW-FSP serves youth in foster care placements outside of San Mateo County who risk losing their current residence and/or at risk for placement in a higher level of care. This program services youth ages 6 to 21 and their foster parents/caregivers and parents/family members. Typically, this youth population has experienced some crisis or safety issue in their home or has had a history of multiple placements.

Services include community-based, in-home, individual, and family therapy; personal rehabilitation; case management, linking participants and families to natural and community resources; psychoeducation; integrated medication support services; and crisis intervention. Services are available to participants and their families 24 hours a day, given a target population prone to significant emotional and behavioral disruptions resulting from family stress, extreme behaviors, and care fatigue. Typically, service delivery occurs in the afternoon and evening. Staff otherwise tailors service delivery schedules for each participant's convenience. Participants can access services on weekends and after-hours through the on-call service. A central part is establishing the Child and Family Team (CFT). Key team members include the youth, caregiver/family, FSA worker, FF team, and interested parties. The CFT meets at least every 90 days to develop the coordination plan. The family is instrumental in voicing their needs and priorities. The hope is to get the youth and family invested in the change they express as urgent and help the family meet those needs.

Program Impact

Out-of-County FSP	FY 2021-22
Total clients served	5
Total cost per client	$10,000
Cost per contracted slots	$5,000

The EBW FSP program does many things to improve timely access and linkage for underserved populations, such as meeting youth/families in the community at convenient locations. The team consists of youth and parent partners who have "lived experience," and sometimes having a staff team member with similar struggles breaks down some barriers to cautious service participants. Attempting to reduce stigmatization through thoughtfulness and respect is an approach to service. The EBW FSP program tries to educate the youth and family on typical child development and help them better understand the impact of trauma on how symptoms manifest. Helping youth and parents better understand the function that trauma might be playing can reduce the sense of being alone in their struggles.

Staff is currently getting training and support on racial equity through racial affinity groups. The staff attends these groups monthly to address privilege and racial issues. The hope is that staff are better equipped to understand race's impact on youth, caregivers' and their own lives. The program hopes to have more meaningful discussions and be more thoughtful and culturally responsive in their actions so that families feel safe and valued in their care.

Wraparound services are not commonly offered throughout the Bay Area. The EBW FSP program has been proud to provide this evidence-based approach to families. Many of the youth served would not have had success in traditional counseling services. This approach certainly helped increase the number of individuals receiving public health services. All referred youth have been screened and approved for services and "do what it takes" to help start a positive engagement process. The program aims to treat all youth referred with equal enthusiasm and professional care.

All staff is trained in Motivational Interviewing (MI) strategies and philosophy. MI is helpful for staff to recognize the different ways a youth displays their readiness for change. Staff meet the youth where they are at and help them see the positives and negatives of their choices. Validating the youth and hearing them out are powerful tools for implementing recovery principles. Encouraging staff to get a different perspective helps prevent staff burnout.

Successes

“Anthony” is a 15-year-old bi-racial (Black/Latino) male who was referred to East Bay Wrap (EBW) due to behavioral issues including aggression and property destruction. He was having difficulty self-regulating and managing his anger and was at risk of expulsion from school. His mother died when he was six years old, and his father had limited involvement due to his own struggle with drug addiction. At the time of referral, Anthony was living with his maternal

grandmother in a homeless shelter. The grandfather did not want Anthony in the home due to Anthony's aggressive behaviors and safety concerns with the other children, so the grandmother moved out with Anthony and into a shelter.

The EBW team supported both Anthony and his grandmother. The Care Coordinator worked on behavioral interventions with Anthony by teaching him coping skills when he felt anger or frustration. In working with Anthony, the team agreed with the grandmother that he should be assessed for a possible developmental disability. This involved many hours of case management, advocacy and working side by side with the grandmother to get an assessment completed. At the end of the assessment, Anthony was given a diagnosis of Autism which qualified him for Regional Center services. The Child and Family team which included the Child Welfare Worker and the Regional Center case manager, in addition to the grandparents, all agreed that Anthony needed a temporary residential placement to stabilize.

While the EBW team usually works to avoid residential placement and keep the child at home, in this case, Anthony did go to a short-term residential placement and EBW services ended. Anthony was successful in residential placement and returned home to his grandmother and grandfather's house in less than six months. The grandmother called the Care Coordinator to express her gratitude to the EBW team for supporting her and Anthony and getting him the needed services that allowed him to return to his home and to live safely with his family.

Challenges

A main challenge is the shrinking population in the program. The program had predicted that the start of AB 1299 would reduce the enrollment and it has seen that as evident. The good news is that foster youth can now more easily access mental health services when they are living out-of-county, but wraparound services specifically are not always available, so referrals are limited. They continue to meet with their program partners and reach out to past staff who made referrals. Staffing is a significant challenge for this program now during the current workforce shortage in the field. The agency increased salaries and now have a sign-on bonus to attract new job applicants. The agency now has a job recruiter and have seen some improvements in bringing in new staff to the department/agency.

TRANSITION AGE YOUTH (TAY) FSP

COMPREHENSIVE TAY FULL SERVICE PARTNERSHIP

Edgewood's Transitional Age Youth Full Service Partnership (TAY FSP) program is a specialized mental health program designed to meet the unique needs of up to 50 high risk and highly acute 16-25-year-olds in San Mateo County. Considered the last treatment option prior to a

residential placement, the TAY FSP provides intensive, round the clock support to help youth reach and maintain stability in the community. The TAY FSP program team meets youth "where they are at" both in terms of physical location as well as at each client's stage of change- simultaneously working to address the youth's identified needs while also building awareness around the choices and behaviors that oftentimes lead to isolation, hospitalization, incarceration, homelessness, and increasingly risky substance use.

The TAY FSP engages as much of the youth's biological family, chosen family, and other permanent, supportive adults to support the youth's treatment, but most importantly to be the network of support once youth have graduated from the program.

While the internal team creates a comprehensive network of support around each youth, the ultimate goal is for youth to develop skills, strengthen their natural support system, and learn when and how to deploy their tools for healthy, independent living.

Program Impact

Comprehensive TAY FSP	FY 2021-22
Total clients served	167
Total cost per client	$17,022
Cost per contracted slot	$56,854

Over the FY 2021-22, TAY worked closely with BHRS contract monitors to identify a few areas that slowed the referral/linkage/access process for TAY FSP referrals. These areas included inconsistency in the response to referrals; misalignment on what was necessary for a completed referral; and lack of a clear timeline on the stages of a referral process. To address these issues, TAY implemented the role of Clinical Intake Coordinator whose primary functions are to attend the referral committees, manage the referral process, communicate with the referent and assign the case. Through the partnership with BHRS, TAY resolved and are now aligned on what is needed for a complete referral as well as came to an agreement on timelines for connecting with referents and clients. These strategies resulted in clear improvement in this process- as evidenced by the feedback from county partners. Ongoing strategies to ensure timely access and linkages start with identifying and addressing the barriers.

- Barrier- youth's perceived accessibility of treatment providers: a team of providers is maintained who are diverse in language, culture, ethnicity, and sexual orientation, gender identity and expression, as well as educational and experiential background to mirror the diverse demographics of the youth referred to the program.
- Barrier- youth's predictable, age-appropriate disengagement from services: persistent and creative techniques are utilized to initiate and sustain youth's engagement with the program like searching for participants at their known community hangouts and incentivizing attendance at sessions by meeting at the TAY Drop-In Centers. Additionally,

most of the youth have been involved in public systems for years without the opportunity or voice to direct their services. Therefore, the youth's lead is followed in what services they needed and how best to support them.

- Barrier- youth's schedules: work schedules are flexible to meet the scheduling limitations of TAY who are employed, in school, parenting, engaged in healthy, extra-curricular activities, or sleep in on a regular basis.

Edgewood's values of family, community, hope, and diversity are infused throughout staff onboarding and training. While in new hire training, providers are oriented to the history of behavioral health stigma and discrimination. Edgewood seeks to ensure that all providers have extensive training in modalities that seek to address these systemic issues related to behavioral health. Edgewood's ongoing staff development yields practitioners who are adept at utilizing a hybrid model of harm reduction, trauma-informed care, and wraparound principles. TAY FSP staff and leadership are aware that mental health treatment and evidenced-based practices may serve as a mechanism of cultural oppression rather than recovery, therefore the program continues to evaluate practices and request feedback from clients regarding how services are experienced by them. Staff are offered in-depth training on gender-affirming treatment as well as multicultural therapeutic practices. This has also been instrumental in meeting the needs of the increasingly diverse transition age youth population. Providers build engagement and access to services by taking time to learn about a client's preferred methods of skill-building and wellness practices. Providers create or adapt interventions to best serve each unique TAY in the program.

Edgewood as an agency leans heavily on Ecological Systems Theory to train providers how to holistically engage and work with clients and their families. In alignment with that approach, the TAY FSP encourages its staff to engage in ongoing behavioral health education and supports providers to develop flexible, individualized approaches to treatment that address every system that impacts a client's life. Each client is considered independently; FSP does not operate under a one-size-fits-all model. At the outset of services, this includes setting the pace for rapport-building and engagement in clinical work based on each individual client's readiness to participate in services. At the point that TAY come into the program, they often have been victimized by and are untrusting of programs or systems they have been involved with in the past. Often these systems have served to stigmatize their mental illness and have limited their hopes for the future. Taking the time to prove the investment in their vision of the future engages TAY in a way that typically helps them reach beyond where they or others have ever thought they could go in their own wellness and functioning.

Microsystems work includes offering psychoeducation to a client and their support network about serious mental illness. Special consideration is given to naming the intersectionality of factors that contribute to the complexity of each client's behaviors and treatment. Some of those factors could include gender expansiveness, identification with the LGBTQ community, neurodiversity, differences in physical ability, past experiences of trauma, and racial identity.

Ecosystems work includes encouraging TAY to expand their support networks to include chosen family, community members, and local resources as well as helping them practice reaching out for support. Prioritizing outreach to local police jurisdictions (e.g., offering crisis intervention training, partnering with mental health clinicians, etc.) and hospitals to partner around improving collective response to mental health crises. This level of systems work also includes offering space for staff to participate in workgroups, committees, and community initiatives that affect TAY in the community. Edgewood values the agency's engagement with the communities that they serve and seeks to have a presence at local events such as the *Soul Stroll, Pride Fest, and Transgender Day of Remembrance*. Community involvement helps advocate and give voice to clients in spaces that they may not feel welcome or seen. TAY values the role in maintaining visibility for the TAY population and championing higher standards of behavioral healthcare for TAY.

Macrosystems work means the agency and FSP provide advocacy on the county, state and federal level for policies and funding that will positively impact TAY, especially those experiences serious mental illness. Each TAY client is unique, and this includes their individual barriers to receiving public health services. Every client's treatment team is tailored to their specific needs. The providers on the team collaborate extensively to connect the TAY with services available in their community that are the best fit for their personal goals, be it achieving sobriety, earning a GED, or a myriad of other activities.

To ensure the facilitation linkage to needed resources, TAY FSP Case Managers stay abreast of what resources are available to the clients and how to access them. This can include Medi-Cal or other health insurance coverage, Social Security Income, and other health and wellness services available in the county. To further assist with this effort, Behavior Support Specialists help clients decrease behaviors that may get in the way of accessing or engaging with health services. Finally, the Independent Living Skills specialists are available to work on the logistical components related to accessing services such as using public transit, obtaining and maintaining important documents (e.g., identification cards), or managing an appointment calendar. The program's chief strength in reducing disparities is the ability to maintain a flexible programmatic structure that can be easily adapted to meet the changing needs of the caseload at any given time. One excellent example of this was the nimble response to the COVID-19 pandemic, which ensured the continuation to reach the vulnerable clients even as they operate under increasingly restrictive conditions. TAY FSP takes pride in the value that there is no "one way" to receive treatment and no predetermined course in the program. The providers are not easily discouraged by behaviors that others may label as "resistant" or "unengaged." TAY FSP celebrates engagement on any level and works hard to build upon it. This helps the team establish trust that supports further engagement and progress.

TAY FSP also employs a culturally and ethnically diverse workforce with a wide variety of educational and experiential backgrounds. Diversity in the workforce brings diversity to the

understanding of each unique client and creates space for “out-of-the-box” approaches to treatment. Commitment to being a trauma-informed program means the employment of very broad definitions of what constitutes engagement and recovery, among other aspects of treatment. This illustrates another facet of the wraparound principle of meeting clients “where they are.” Edgewood’s TAY FSP integrates trauma-informed practices and a harm reduction stance with a strong foundation in the principles of wraparound to support TAY through their treatment with the program. Utilization of a recovery-oriented approach that allows TAY to set their own vision and build agency to reach their goals. Partnership with other programs in the county that treat co-occurring disorders as needed to support all facets of a client’s recovery.

Successes

Edgewood’s TAY FSP is proud of the work the team has been able to do with clients over the past year, despite many challenges and hardships. From a year fraught with challenges, several bright spots have emerged in the program. *Names have been changed for privacy purposes:

Paula, she/her, is a 22 year-old client who entered the TAY FSP in July of 2021. Paula came into the program having attempted suicide several times, exhibiting a violent history towards family, isolating tendencies, PTSD and Eating Disorder behaviors. At the time of the referral, she had been hospitalized several times in prior months and was conserved by a public guardian.

Due to the volatile relationship with her family, Paula was in social rehabilitation programs for the majority of the time she was in the program. During her time with the TAY FSP, Paula’s services included case management, one on one coaching with a guidance and career specialist and a behavior coach, and individual therapy. Paula accessed the psychiatry services as well as the crisis response line.

Over the last year, Paula stayed focused and worked incredibly hard to get to where she is today. Paula has reconnected with family that triggered her PTSD/ED and addressed concerns with them independently. Paula advocated to be taken off her conservatorship, which she was granted for all her hard work in the treatment programs she has been in. Paula became medication compliant after not being complaint for years prior and is responding well to the medication regiment. Paula has developed consistent daily meal eating patterns to stay healthy. Paula is currently now living back home with family, enrolled in classes and not in isolation. Paula has reported spending more time with her siblings and is currently working to rebuild her relationship with her father.

Challenges

The main challenge this reporting year has been recruiting the Family Partner role, which is a crucial part of the treatment team- someone with their own experience raising a child or family member who has been in a public system- using that shared, lived experience to connect with and guide the parents and caregivers of clients. While this role is typically quite

welcomed among youth wraparound FSP services, it is more challenging within the TAY FSP.

TAY are adults and, unless they are conserved, have the right to participate in or decline services and provide or revoke authorization for TAY to speak with anyone about their services. While this can be quite liberating for a young person, it also can be incredibly difficult for a parent or caregiver to accept and navigate the system when they are no longer in charge of their child's care. The Family Partner plays an important role in helping the parents/caregivers in this transition from a lead role to a support role, especially if they do not agree with the choices that the youth is making.

Recruiting this role is challenging because the minimal qualification is the lived experience. Not many parents/caregivers who have the lived experience are interested in this work or removed enough from their experiences to support others in a healthy way. Another challenge had been the salary. The state has created a Medi-Cal Peer Support Certification which is believed to help give more credibility to the role of a Family Partner. The hope is that this will elevate the status and recognition of peer roles will help with recruitment. At Edgewood, specifically, the entry level salary for peer support roles has been raised to make the role more attractive as well.

ENHANCED SUPPORTED EDUCATION

Caminar's Supported Education program at the College of San Mateo has been highly successful in supporting individuals with mental health/emotional needs in attending college and achieving academic, vocational, and/or personal goals. This program was established in the spring of 1991 from collaboration with the College of San Mateo, Caminar, and the County of San Mateo's BHRS program. The program's unique approach combines special emphasis on instruction, educational accommodations and peer support to assist students to succeed in college. Traditionally, the attrition rate for individuals with psychiatric disabilities has been exceptionally high as a result of anxiety, low stress tolerance, lack of academic and social skills, and low self-esteem. However, this program has become an innovative leader in reversing this trend. Started in 2016 at Skyline College, Future Views supports potential students with an introductory class and one to one counseling and tutoring.

In addition to the campus presence, the Supported Education program has an extensive presence in the community, with regular groups at Caminar's residential programs such as skills groups, self-care groups, activity groups, and processing groups. There is also a weekly Drop-In time for clients to get school and career assistance. The Supported Education program is also a part of the Diversity and Equity Council and the Behavioral Health Commission youth committee.

The Supported Education program strives to reach out and engage individuals who can benefit from engagement in the supported education program. To this end, the supported education program team has reached out to a wide number of community programs throughout the fiscal year, to reach out and engage clients into supported education services, thereby initiating a

pathway of recovery, support and empowerment. Once engaged in the supported education program, clients begin to see their potential and the opportunities available to them.

Classes and groups also build on recovery principals such as WRAP (Wellness Recovery Action Plan), personal and career skills-building, resource education and linkage, empowerment through education and career development, leadership potential, having a peer support group, and engagement utilizing active listening, motivational interviewing, and supportive engagement.

Providing a pathway for clients into a new identity as a student, Peer Counselor, or other career pathway greatly increases personal self-esteem and helps re-write the 'client' narrative, thereby decreasing the stigma commonly associated with persons receiving mental health support and services. Caminar's Supported Education program provides such a pathway of opportunity, and it remains essential that all of San Mateo County clients are given information of and access to the supported education program.

Program Impact

Supported Education	FY 2021-22
Total clients served	93
Total cost per client	$2,133

The supported education program focuses on connecting 20 individuals with educational/vocational services and by providing individualized supports. With these supports, the cohort GPA and retention rates are as follows:
Students attending Fall and Spring semesters of the Peer Counseling program:

- achieved an overall GPA of 3.6
- Attained a retention rate of 83%

Additionally, through the development of supports such as staff and student support groups, the individual client benefits from a supportive, nurturing and empowering environment that fosters self-reliance, self-care, and in turn decreases the isolation and stresses that often precipitates an increase in symptoms or a decrease in functioning.

- 100% Reported that their class experience was satisfactory or above

Curriculum Summary

- Peer Counseling Class 1 Fall. Orientation, HIPAA, boundaries, Carl Rogers' Active Listening, Hierarchy of Needs, Humanistic Psychology, Overview of Academic Programs, Group Facilitation, Communication Essentials, Wellness Recovery Action Plan (WRAP), American Counseling Association (ACA) Ethics, Self-care, Diversity and Equity Programs, and the Models of Recovery.
- Peer Counseling Class 2 Spring. Review of Active Listening, Motivational Interviewing/Stages of Change, Harm Reduction Models, Object Relations Model, Classical/Operant Conditioning, Cognitive Behavioral Theory, Problem Solving, DSM 5,

Assessment Concepts, Developing a Treatment Plan, Writing Progress Notes/BHRS Documentation Guidelines, and a career project.

Fall Semester- 10 students completed the Peer Counseling 1 class

Spring Semester- 9 students completed the Peer Counseling 2 class

- 4 students are working, 2 are continuing school.
- The program served 93 unduplicated clients, with 20 TAY (transition-age-adults)
- 139 Hours of service were provided (8,380 minutes)
- 106 groups and activities for TAY clients were offered
- 106 engagement activities for TAY were offered (classes, groups, outings, one to one activities)

Successes

The College of San Mateo (CSM) has continued with distance learning for most of their classes and covid policies for enrolled students of CSM only allowed on campus. The Peer Counseling class has continued with the RingCentral Zoom on-line format, which seems more accessible to those students who otherwise have challenges commuting to campus. Additionally, this has also helped them to be able to check-in weekly and become more fluent in alternate methods of communication. The entire counseling class needs to be recognized for their inspiring perseverance, adaptability, engagement, and support of each-other. Whichever direction they chose, they are sure to not only have a positive impact, but also, and most importantly, they will be a support and inspiration to other clients.

Challenges

1. Clients can often need extra assistance and, in some cases, upgraded devices to be able to join on zoom activities. Programs increasingly assist their clients with grant-sourced devices to aid in their connectivity.
2. Referrals/Connecting- conducting outreach and community activities during covid-19 has been modified. The supported education program has a strong focus on outreach and engagement activities to reach as many clients and programs as possible and offer the support and program opportunities available. The Supported Education program will continue exploring alternative outreach strategies in the coming year.
3. Transition-Age-Youth (TAY) present with challenges in engaging and needing support in life and career goals and the continued housing crisis that directly impacts their stability and overall health and well-being. As age-appropriate, TAY often prefers doing activities with other TAY and do not want to identify with a 'specialized' program. While this is important for connection and self-esteem, it represents challenges for helping professionals in engaging, guiding, and supporting. Nonetheless, this is a critical area of focus, as helping to guide and support TAY in their growth, exploration, and development is both essential and highly rewarding.

Demographics

			FY 2021-22
Age		**Race/Ethnicity**	
0-15	9%	Latino/a	56%
16-25	3%	Pacific Islander	0%
26-59	86%	Asian	2%
60+	2%	Chinese	1%
Unknown	1%	Black/African/-American	2%
Primary Language		White/Caucasian	3%
English	17%	Filipino	3%
Spanish	80%	Asian Indian	1%
Mandarin	1%	Puerto Rican	1%
Tagalog	1%	Samoan	1%
Unknown	1%	Fijian	1%
Gender Identity		South American	9%
Male	24%	Another race/ethnicity	8%
Female	74%	Unknown	10%
Decline to state	1%		
Unknown	0%		
Two-spirited	0%		
Sexual Orientation		**Veteran**	
Gay, lesbian, homosexual	0%	Yes	2%
Straight or heterosexual	84%	No	95%
Bisexual	0%	Unknown	2%
Decline to state	14%		
Unsure	2%		
Unknown	0%		

ADULTS AND OLDER ADULTS FSP

ADULT AND OLDER ADULT/MEDICALLY FRAGILE FSP

The FSP program, overseen by Telecare, Inc., provides services to the highest risk adults, highest risk older adults/medically fragile adults. Outreach and Support Services targets potential FSP enrollees through outreach, engagement and support services. These programs assist consumers/members to enroll and once enrolled, to achieve independence, stability and wellness within the context of their cultures and communities. Program staff are available 24/7 and provide services including: medication support, continuity of care during inpatient episodes

and criminal justice contacts, medical treatment support, crisis response, housing and housing supports, vocational and educational services individualized service plans, transportation, peer services, and money management. Services specific to Older Adult/Medically Fragile include maximizing social and daily living skills and facilitating use of in-home supportive agencies.

Telecare FSP, via the integrated teams model uses daily morning huddles to assertively coordinate and track the various service needs for every individual the teams serve. Including benefits acquisition, psychiatric appointments and medication, case management and evidence-based rehabilitation and other promising practices, the teams proactively identify needs and gaps in service and provide, broker or advocate for those necessary services or resources. The concentrated effort of each team affords the opportunity to engage in continual improvement for clients lives by circling back on progress made in all the areas identified.

Telecare delivers excellent and effective behavioral health services that engage individuals with complex needs in recovering their health, hopes and dreams. Utilizing a team-based approach, clients have 24/7 access to a team member that has working knowledge of their hopes and dreams, treatment plan goals, interventions that have worked and those that do not. Furthermore, each team incorporates titrated services ranging from the most intensive (FSP level) through Case Management and into Wellness.

These levels allow members to progress in their recovery journey while keeping their support team intact and allows for aging members to move back into higher levels of support, keeping their support team intact. All service recipients are adults or older adults that are on their recovery journey from complex behavioral health challenges including serious and persistent mental illness, co-occurring medical issues, substance use, criminogenic profiles and more.

Activities, services and interventions include but are not limited to assessment and treatment planning, psychiatry, case management, medication support, vocational development/ brokerage, supported education brokerage, numerous evidence based and promising practices such as Motivational Interviewing, Wellness Recovery Action Plans (WRAP), Seeking Safety, Recovery Centered Clinical Systems (RCCS), Screening, Brief Intervention and Referral to Treatment (SBIRT), etc.

Program Impact

Telecare Adult/Older Adult FSP	FY 2021-22
Total clients served	257
Total cost per client	$9,126
Cost per contracted slots	$11,330

Improves timely access and linkages for underserved populations
With very few exceptions, initial meetings with new clients occur in less than 3 business days of the referral. Engagement, assessment, and treatment plan development start in that initial meeting.

Reduces stigma and discrimination
The multi-disciplinary teams are comprised of varying professions (Case Managers, Licensed Clinicians, Nurses, and a Prescriber). Still, they also comprise a high number of individuals with lived experience. Approximately 80% of the Telecare teams are individuals on their recovery journey. This normalizes the process, establishes rapport, and reduces stigma.

Increases number of individuals receiving public health services
The program takes almost all client referrals, with few exceptions. They refer, link, and connect clients with various public health providers. Within the first two weeks of working with a new member, the team searches for benefits to which the member is entitled and helps establish those benefits for the member.

Reduces disparities in access to care
Daily team huddles are conducted, and members' circumstances are reviewed to ensure that all members have access to but are not limited to the following: psychiatric and medical care, financial benefits, access to housing options, food security, vocational and educational resources. Furthermore, as part of San Mateo County's system-wide effort to improve care coordination for individuals with complex needs, Telecare FSP participates in cross-over collaborative efforts and has representation at the planning level.

Implements recovery principles
Telecare's clinical model, Recovery Centered Clinical Systems (RCCS), is at the core of operations. The staff focus on recovery in the aspects of the care provided.

Demographics

257 Participants	**FY 2021-22**		**FY 2021-22**
Age		**Race/Ethnicity**	
up to 23	0.29%	American Indian/Indigenous	1.15%
24-34	14.10%	Asian	18.24%
35-44	27.10%	Latinx	0%
45-54	22.37%	Pacific Islander	01.76%
55-64	25.12%	Eastern European	0%
65+	11.02%	European	0%
Sexual Orientation		Arab/Middle Eastern	0.9%
Gay, lesbian, homosexual	.9%	Black/African/-American	0%
Straight or heterosexual	50.5%	White/Caucasian	51.89%
Bisexual	5.8%	Asian Indian/South Asian	0%

Queer	0.0%	Central American	0%
Questioning or unsure	2.9%	Chinese	1.15%
Pansexual	2.9%	Mexican/Chicano	0%
Another sexual orientation	.9%	Filipino	0.23%
Decline to state	37.9%	Japanese	0.23%
Gender Identity		Korean	0.23%
Male/Man/Cisgender	66.42%	Another race/ethnicity	23.12%
Female/Woman/Cisgender woman	32.82%	Decline to state	0%
Other	0.76%		
Decline to state	0%		

Successes

There are several of members who continue to demonstrate strong paths of recovery and are role models for others in their community that it's possible to achieve one's hopes and dreams. Telecare FSP continues to provide excellent services and interventions to the individuals served. Over the past several years, the Telecare FSP's have focused on:

- Using intentional service delivery (based on a member's stated preference of goals in their treatment plan, staff know what behavior they want to address and what interventions they will use prior to going out to see the member)
- Observing clinical efficacy in addition to capturing outcomes other than MHSA (meaning, did the intervention work in addressing the behavior and did the member get the outcome they preferred)
- Sharing these observations with the individual member
- Further partnering with the member using Motivational Interviewing (MI) and Recovery Centered Clinical System (RCCS) conversations to highlight their choice in both interventions and hoped for outcomes
- Reduce the duration of untreated mental illness
- Prevent mental illness from becoming severe and disabling

The Telecare FSP continues to enjoy a reputation as being a very successful service provider and partner for residents of San Mateo County. Referrals are consistently enrolled within 3 work days of receipt and new members are engaged immediately upon referral. Safe and affordable housing options have been available for those referrals over 85% of the time there's a need.

Telecare Transitions has reduced homeless days with enrollees by 92.9%, reduced hospitalizations by 82.5 % and reduced incarcerations by 98.1%.

Challenges

This year has seen numerous challenges: the ongoing pandemic, the great resignation, the onset of recession, increased costs of living, fuel and food prices at all-time high, to name but a

few. As with previous reports for several years now, funding continues to be far below operational costs and, while staff turnover at the program is low, the replacement rate is far lower with some key leadership positions remaining vacant for over a year.

Ongoing issues around COVID mitigation (staffing issues, purchasing PPE, etc.) further hampered onboarding and, on occasion, if services were in person or remote. Fortunately, Telecare FSP has been able to leverage Telehealth options to support members when in person services was not an option.

COMPREHENSIVE FSP FOR ADULTS AND OLDER ADULTS

Caminar's FSP program is designed to serve the highest risk adults and highest risk older adults, medically fragile. Most adults with SMI served by FSP have histories of hospitalization, institutionalization, and substance use, are not engaged in medical treatment and have difficulty participating in structured activities and living independently. Older adults have cognitive impairments and medical comorbidities. The purpose of this program is to assist clients in enrolling and achieving independence, stability, and wellness within the context of their culture and communities. This program aims to divert clients from the criminal justice system and acute, long-term institutional levels of care and help them succeed in the community. The program strives to help them achieve their wellness and recovery goals, maximize their use of community resources, integrate clients' family members or other support people into their treatment, achieve wellness, independence, and improved quality of life.

FSP has a staffing ratio of staff to consumers, with a ratio of 10:1. FSP can serve 30 clients. There are frequent team meetings to discuss clients in crisis, hospitalizations, incarcerations, med non-compliance, and homelessness. A psychiatrist is assigned to the client to provide medication evaluation and psychoeducation. Case managers assist clients with needs related to mental health services, rehabilitation, housing, employment, education, social and recreational activities, and health care. Consumer treatment includes a variety of modalities based on consumer needs, including case management, individual, group, or family therapy, psychiatric medication prescription, and general medication support and monitoring. Consumer self-help and peer support services include money management, employment opportunities, social rehab, and assistance with referrals and housing.

Caminar also provides community based-nursing to assist clients with improving medication compliance. FSP services are delivered by a multidisciplinary team, which provides 24/7 crisis response support, including in-home support services and services at other consumer locations as appropriate. Case managers help plan for linkage to and coordination with primary care services to strengthen the client's ability to access healthcare services and ensure follow-up with detailed care plans.

Program Impact

Caminar Adult/Older Adult FSP	FY 2021-22
Total clients served	33
Total cost per client	$57,136
Cost per contracted slot	$62,849

Caminar reduces suicide by rapid and consistent engagement with clients and their collateral providers, case conferences, increasing contact with clients who may be decompensating, 24/7 availability, and CPI protocol and training. The program limits school failure and dropout through the Supported Education program. It helps lower unemployment by utilizing the Jobs Plus program, which provides skills training and referrals to employers looking for workers. Homelessness is a pervasive problem in the Bay Area and San Mateo County, in particular. Caminar provides housing options to clients in need of independent apartments and shared apartments through the Supported Housing program. In collaboration with BHRS, FSP links clients to multiple housing options: Licensed Board and Cares, Single-Room Occupancy (SRO) rooms, shelters, and unlicensed room and boards.

By utilizing the social rehabilitation model, which provides a non-judgmental, normalized environment that emphasizes the client as the lead in their care, Caminar works to reduce the stigma and discrimination their population often faces. They further ensure linkage to outside community providers for primary care and ensure ongoing collaboration with said providers and staff; this helps ensure that clients receive public health services. By partnering with other non-profit agencies, Caminar helps reduce the disparities in access to care. Finally, they utilize Harm Reduction, MI, DBT, and WRAP to help strengthen clients' gains and implement the principles of recovery throughout all of their programs.

Successes

“Sarah” has shown amazing growth over the past few years. She has developed many skills to help her with management of her symptoms and stabilization in the community. She completed chemotherapy for breast cancer while maintaining housing and keeping all her mental health appointments. She has become a self-advocate for physical and mental health needs. Sarah has become more independent and recently became her own payee. She has requested a reduction in services as she can recognize her growth and stability. Sarah is looking forward to stepping down from FSP to a low level case management program this year.

“John” is currently at a social rehab to work on his independent living skills and to transition back into community living. He has shown great improvement in improving his symptom management. Before joining the FSP program John was in and out of jail and unable to manage his symptoms independently. He was cycling frequently and unable to manage basic daily care. He has recently been able to improve on his learning of skills to manage his symptoms and manage to develop and practice daily living skills.

Cultural responsiveness trainings and addressing inequalities in the community: As a response to the need to increase staff's competency of structural racism in the community and the need to be culturally responsive to provide the best quality of services to FSP diverse population Caminar has continued a monthly Diversity and Equity Committee. Weekly Staff meetings continue to include time to discuss staffs own personal experience with racism, biases, and allows space for staff to share their own culture with their team with the purpose of also celebrating staff's diversity.

A training was provided on Culture Competence: Exploring Culture and Identity/Resource Exploration. This interactive training guided staff to explore how elements of identity and culture influence who they are and how they relate to the people and the world around them. Individual identities are formed through processes that started before birth. Expanding the understanding of people and the world begins with understanding identity and how cultural values influence views of the world and others. The session supported learning and awareness of how identity influences how individuals experience and impact the culture of the workplace. Staff learned about cultural differences and similarities by exploring their own identity and cultural values and reflecting on the practices, norms, and values of the host culture at Caminar. Additionally, staff learned about internal resources offered at Caminar and the resources within the Community of clients.

Trainings and Evidence based practices: Since early 2021 Caminar has been implementing a Feedback Informed Treatment (FIT) pilot. During this fiscal year reporting, the use of the tool was officially rolled out to all Case Management programs. The staff have all been trained and receive support in monthly meeting to continue to improve on their use of the tool. FIT uses routine provider alliance monitoring (Session Rating Scale) and routine outcome monitoring (Outcome Rating Scale) which in the FIT evidenced-based practice model can double reliable, clinically significant positive change (the "effect size"). FIT provides the opportunity to surface and correct problems with engagement and the alliance (including any issues related to culture or diversity), and/or lack of progress to reduce negative outcomes such as poor engagement and early dropouts.

- All staff have been trained in Motivational Interviewing (MI) with follow up weekly labs for two months of weekly labs to continue practicing the interventions to use with their clients. Monthly labs are continued to be offered to staff to increase their skill set ultimately leading to more successful interventions with the clients.
- All staff were trained in the use of SAFE-T tool for assessing clients for danger to self to address in the moments the severity of client's statements for suicidal ideation. The training provided experiential practice on a two part series for the staff to build confidence in using the tool and asking the questions. Quarterly SAFE -T tool refresher

trainings have been established to keep the staff mindful of how to assess a client for suicidal ideation.

- All staff have been trained in Pro-ACT is based upon a set of Principles that focus on maintaining client dignity while keeping clients and staff safe. Employee In-service training and is designed to: Respect client rights; Build a non-coercive treatment environment; Minimize the risks associated with emergency response to assaultive behavior; Emphasize the role of supervision of employee behavior; Support continuous upgrading of skills and knowledge; Be free of gender bias; Emphasize team skills; Provide experience in problem solving.

Succession and Retention Planning: As part of the commitment to foster growth and development of staff as well as retention for consistency of services to client care. Caminar has continued to meet to discuss the succession and retention of staff. During this reporting year, two clinician roles were created to increase the number of clients in the FSP programs who can be offered therapy services. The clinicians were also sent to be trained in DBT interventions so that they can develop a skills group for the clients and a training group for the staff to support the clients in continued use of the skills they are learning.

Challenges

*Impact of COVID on community connections***:** COVID impacted the community connectiveness that many of the clients gained from Caminar and other community organizations who had to go virtual for their groups. This lack of social engagement and isolation has made it difficult for many of the clients to now leave their homes and rejoin community. There has been a growing trend in clients where the pandemic created or increased issues with client's social anxiety and willingness to leave their homes. Maintenance of housing and ADLS have declined, and medical issues have also increased.

Housing: The limited housing options for clients given the continued increase in housing costs in the Bay Area along with their low incomes continues to be the biggest challenge for FSP. There are not enough supported living environments in the area to support the level of care in housing that the FSP level client needs. In addition, clients reflect an aging population and as such have an increase in medical needs and their medical issues become a dominant component of their lives.

Housing subsidies: Housing subsidies that are linked to FSP have been a barrier to stepping down a number of clients. If they are stepped down to a lower level of care, they lose their housing subsidy, which means they lose their housing. Caminar continues to seek alternate forms of non-program dependent housing subsidies and/or vouchers that are not tied to the FSP program.

*Comorbidity***:** Clients are continuing to experience major medical concerns in the FSP program. These clients will need long term medical assistance but are currently being managed in the community or temporarily placed in SNFs in the hopes of returning to the community. All FSP

clients are continuing to be seen weekly for at least two hours by their case managers, nurses, psychiatrists, assistant case managers and/or wellness support specialists. Many of these clients may need to be assessed for IHSS services so they can continue to live independently, but also live safely in their environment and to ensure their needs are met.

ASSISTED OUTPATIENT TREATMENT "LAURA'S LAW" FSP

The purpose of Assisted Outpatient Treatment (AOT) Full Service Partnership (FSP) is to provide services to individuals with serious mental illness who currently are not receiving treatment and may or may not require court intervention to receive treatment. AOT FSP services are based on the Assertive Community Treatment (ACT) model.

AOT FP target population are adult San Mateo County residents living with serious mental illness (SMI) who meet the eligibility criteria listed below as specified in Assembly Bill 1421:

- Unable to "survive safely" in the community without "supervision"
- History of "lack of compliance with treatment" as evidenced by at least one of the following:
    - Hospitalized/incarcerated two or more times in the last 36 months due to a mental illness
    - Violent behavior towards self or others in the last 48 months.
    - Previously offered treatment on a voluntary basis and refused it or are considered "deteriorating."

Program activities include engaging Individuals who have not had a successful and lasting connection to treatment and recovery services. Diversion from the criminal justice system and/or acute and long term Institutional levels of care (locked facilities) SMI and complex Individuals with multiple co-morbid conditions that can succeed in the community with sufficient structure and support. Caminar offers a "whatever it takes" to engage complex adults and older adults with SMI in a partnership to achieve their individual wellness and recovery goals, using alternative models of care which offer greater benefits to them, increasing the likelihood that they will experience positive outcomes.

AOT FSP has a staffing ratio of staff to consumers, with a ratio of 10:1. With a capacity to serve 50 clients. There are frequent team meetings to discuss clients in crisis, hospitalizations, incarcerations, med non-compliance and homelessness. A psychiatrist is assigned to the client to provide medication evaluation and psychoeducation. Case managers assist clients with needs related to mental health services, rehabilitation, housing, employment, education, social and recreational activities, and health care. Caminar maximizes use of community resources as opposed to costly crisis, emergency, and institutional care. Utilize strategies relating to housing, employment, education, recreation, peer support and self-help that will engender increased collaboration with those systems and sectors. AOT FSP establishes and solidifies linkages to medical, health care coverage, social services, and income benefits.

Clinically, Caminar provides interventions from evidence-based practices such as ACT, Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Harm Reduction, Seeking Safety, Trauma Informed Services, Stages of Change, Crisis Intervention and Management, Medication Benefits, Medication Assistance Program (MAP), Wellness Recovery Action Plan (WRAP), and recovery-based treatment.

Program Impact

AOT (Laura's Law) FSP	FY 2021-22
Total clients served	64
Total cost per client	$9,722
Cost per contracted slot	$12,444

Caminar reduces risk by rapid and consistent engagement with clients and their collateral providers, case conferences, increasing contact with clients who may be decompensating, 24/7 availability, and its CPI protocol and training. When indicated, all management staff are trained and certified to initiate involuntary hospitalization. Caminar limits school failure and dropout through Supported Education and helps lower unemployment by utilizing the Jobs Plus program, which provides skills training and referrals to employers looking for workers. Homelessness is a pervasive problem in the Bay Area and San Mateo County, in particular. The Supported Housing program provides housing options to clients who need independent apartments and shared apartments. In collaboration with BHRS, FSP links clients to multiple housing options: Licensed Board and Cares, Single-Room Occupancy (SRO) rooms, shelters, and unlicensed room and boards.

Once a client is referred to Caminar services, staff attempts to initiate contact within two (2) business days for case management and psychiatric services within five days. Clients are assessed rapidly and comprehensively by case managers, the psychiatrist, and Clinic Manager/Registered Nurse (RN). The Clinic Manager/RN completes a Nursing Assessment for all clients admitted to the program. Furthermore, AOT also utilizes MAP to increase medication compliance and reduce the risk of clients overtaking or undertaking their medications.

By utilizing the social rehabilitation model, which provides a non-judgmental, normalized environment that emphasizes the client as the lead in their care, Caminar works to reduce the stigma and discrimination the population often faces. AOT further ensures linkage to outside community providers for primary care and ensures ongoing collaboration with said providers and staff; this helps ensure that clients receive public health services. By partnering with other non-profit agencies, AOT helps reduce the disparities in access to care. Finally, the program utilizes Harm Reduction, MI, DBT, and WRAP to help strengthen clients' gains and implement the principles of recovery throughout all programs.

Successes

Cultural responsiveness training and addressing inequalities in the community:
As a response to the need to increase staff's competency of structural racism in the community and to be culturally responsive to provide the best quality of services to AOT diverse population Caminar has continued a monthly Diversity and Equity Committee. Weekly Staff meetings continue to include time to discuss staffs own personal experience with racism, biases, and allows space for staff to share their own culture with their team with the purpose of also celebrating staff's diversity.

Caminar also provided a training on Culture Competence: Exploring Culture and Identity/Resource Exploration This interactive training guided staff to explore how elements of identity and culture influence who they are and how they relate to the people and the world. Our identities are formed through processes that started before birth. Expanding the understanding of the people and the world begins with understanding identity and how cultural values influence individual views of the world and others. The session supported learning and awareness of how identity influences how they experience and impact the culture they work in. Staff learned about cultural differences and similarities by exploring their own identity and cultural values and reflecting on the practices, norms, and values of the host culture at Caminar. Additionally, they learned about internal resources offered at Caminar and the resources within the community of clients.

Training and Evidence-based practices:
Since early 2021 Caminar has been implementing a Feedback Informed Treatment (FIT) pilot. During this reporting fiscal year, Caminar officially rolled out the use of the tool to all Case Management programs. The staff have all been trained and receive support in monthly meeting to continue to improve on their use of the tool. FIT uses routine provider alliance monitoring (Session Rating Scale) and routine outcome monitoring (Outcome Rating Scale) which in the FIT evidenced-based practice model can double reliable, clinically significant positive change (the "effect size"). FIT provides the opportunity to surface and correct problems with engagement and the alliance (including any issues related to culture or diversity), and/or lack of progress to reduce negative outcomes such as poor engagement and early dropouts.

Caminar has trained all staff in Motivational Interviewing (MI) with follow up weekly labs for two months of weekly labs to continue practicing the interventions to use with their clients. Monthly labs are continued to be offered to staff to increase their skill set ultimately leading to more successful interventions with the clients.

All staff were trained in the use of SAFE-T tool for assessing clients for danger to self to address in the moments the severity of client's statements for suicidal ideation. The training provided experiential practice on a two part series for the staff to build confidence in using the tool and asking the questions. Quarterly SAFE -T tool refresher trainings have been established to keep the staff mindful of how to assess a client for suicidal ideation.

All staff have been trained in Pro-ACT is based upon a set of Principles that focus on maintaining client dignity while keeping clients and staff safe. Employee In-service training and is designed to: Respect client rights; Build a non-coercive treatment environment; Minimize the risks associated with emergency response to assaultive behavior; Emphasize the role of supervision of employee behavior; Support continuous upgrading of skills and knowledge; Be free of gender bias; Emphasize team skills; Provide experience in problem solving.

Succession and Retention Planning:
As part of Caminar's commitment to foster growth and development of staff as well as retention for consistency of services to client care, discussions of succession and retention of staff have continued. During this reporting year, Caminar created two clinician roles to increase the number of clients in FSP programs who can be offered therapy services. Caminar also sent the clinicians to be trained in DBT interventions so that they can develop a skills group for the clients and a training group for the staff to support the clients in continued use of the skills they are learning.

Client Story #1: "Amy"
"I believe Amy is a great example of a client who I have seen improve. Amy was referred to the AOT program in March 2022. She has a history of past hospitalizations, with the most recent being in March. At the time she was exhibiting manic symptoms, experiencing auditory and visual hallucinations (A/V/H), and was severely catatonic when emergency responders arrived to take her to the hospital. When referred to the AOT program, Amy was very difficult to engage with and very unresponsive. She was resistant to taking psychiatric medication, extremely quiet, experiencing A/V/H, as well as suicidal ideation, and was not implementing nor maintaining use of any coping skills. She also had impairments when it came to her social and interpersonal skills which made it very difficult for her to create and maintain relationships outside of her immediate family.

Over the past 6 months, Amy has made a lot of great improvements. She is medication compliant, engaged, and continues to maintain use of her preferred coping skills. Recently, she was able to independently get a job and she has been working for a couple of months. She has been able to increase her engagement with others and build more positive social connections with coworkers. Amy has expressed how she has also noticed these improvements within herself over the past 6 months. She has said she feels like the medication and support by staff has played a big role when it comes to stabilizing her mood and has helped to reduce her symptoms. Amy has also said she notices her improvements when it comes to connecting with others. She feels like she's been able to engage better and is quicker to respond during conversations. In the past, she was very hesitant and quiet but now she can hold a conversation. Overall, Amy appears to be a lot happier and is motivated when it comes to working towards her goals. She wants to move out of her parents' house, get her own apartment, and eventually wants to get another job. Maintaining engagement with case management services, her psychiatrist, as well as her therapist are all things that are continuing to help Amy improve and manage her mental health symptoms."

Client Story #2: "Jane"
"Jane has a long history of struggling with homelessness, alcohol use and mental health challenges. Jane has been able to get off the street, stop alcohol use and has been able to get housing and live in her own apartment within the community of her choice. She has gotten furniture for her apartment and continues to remain stable in her apartment. Her symptoms are well controlled, and she blends in well in the community. Finally, Jane is now looking for work to become more independent."

Challenges

Impact of COVID on community connections: COVID impacted the community connectiveness that many clients gained from Caminar and other community organizations who had to go virtual for their groups. This lack of social engagement and isolation has made it difficult for many clients to now leave their homes and rejoin community. We have seen a growing trending in clients where the pandemic created or increased issues with client's social anxiety and willingness to leave their homes. Maintenance of housing and activities of daily living (ADL) have declined, and medical issues have also increased.

Increase in high risk violent offenders: With the new law SB317 there has been an influx in new client referrals with recent and histories of sexual and physical assaults. For those assessed for Mental Health Diversion, if they're not interested or able to participate in the program, they are either sent to AOT or LPS Conservatorship for investigation. As Caminar encounters more clients with violent behaviors, there has also been on many occasions the refusal from local law enforcement, dispatchers, and ambulances to be present for 5150 situations unless the client is actively causing harm to others.

Housing: The limited housing options for clients given the continued increase in housing costs in the Bay Area along with their low incomes continues to be the biggest challenge for AOT. We still face issues with availably of appropriate level of housing for the level of functioning of the clients served.

Housing subsidies: Housing subsidies that are linked to AOT have been a barrier to stepping down clients. If they are stepped down to a lower level of care, they lose their subsidy, which means they lose their housing. We continue to seek alternate forms of non-program dependent housing subsidies and/or vouchers that are not tied to the AOT program.

MATEO LODGE: SOUTH COUNTY INTEGRATED FSP

The South County Adult Behavioral Health Outpatient Clinic located in Redwood City and serves complex adult client population living with serious mental illness (SMI) and/or Substance Use Disorders (SUD). Due to the location of the clinic the program serves as the catchment area providing services to individuals from the women's and men's county jail, Redwood House crisis residential, Cordilleras Mental Health Rehabilitation Centers (MHRC), three inpatient SUD

treatment programs, and two homeless shelters. The typical client served are considered at risk of self-harm or neglect, recently hospitalized for mental health, poorly engaged in treatment, have co-occurring SUD, often homeless, have trust issue stemming from mental health diagnosis, and have limited community resources.

During FY 2021-22, Mateo Lodge has been contracted to provide 50 hours of service per week for 3 different levels of intensity (A - Task oriented case management 1-2 months, B - Supplemental case management 4-6 months, and C – Full Service Partnership (FSP) clinical case management 6 -12months). The program was staffed for 40 hours/week.

Clients receive 1–3 hours of direct case management contact per week and carry a weighted caseload of 10-12 clients as FSP level clients receive 3 – 5 hours or weekly support. There are currently 15 Embedded Intensive Case Management (ECM) clients, of which 1 also receive voucher support. The voucher-based clients receive quarterly home visits, monthly phone check in, and assistance with negotiation with landlords, etc. in preparation for annual housing inspections, relocation if needed and redetermination paperwork/appointments. At the close of the fiscal year, there was no waitlist for services.

Each ECM client meets with their embedded case manager and completes a “Needs Assessment” to facilitate client goals, to targets case management tasks/activities and updates Level of Care Utilization System (LOCUS) bi-yearly for evaluation of level of care.

ECM provided service to a total of 20 clients’ during this reporting cycle. Clients referred are high risk of hospitalization, recently discharged from locked facilities, or have fallen out of care. The program supports this severe population and provides Spanish speaking capacity. ECM has closed 5 cases and active case load population is 10 Caucasian, 3 Latino, 1 African America, and 1 Vietnamese with age of 31- 81 years old. Level of care has increased such that all clients are receiving (C) supplemental FSP level of service from reporting in FY 2021-22. Client average length of needed support is 1 year.

ECM staff are bilingual Spanish and participate in professional development including Cultural Humility, Sexual Orientation and Gender Identity (SOGI), Management of Assaultive Behavior, Motivational Interviewing, and BHRS required documentation and compliance trainings. Additionally, ECM attend quarterly meetings with Mateo Lodge, weekly county supervision, and bi-weekly staff meeting at South County Clinic. Staff development is targeted to further strengthen ECM awareness of community services, improve cultural appropriate services, and to deepen clinical knowledge of the population of clients served to employ best strategies/practice.

Program Impact

Integrated FSP – South County	FY 2021-22
Total clients served	20
Total cost per client	$6,368
Cost per contracted slot	$8,491

South County has complex impaired SMI clients as it services the county jails, Redwood House crisis residential, Cordilleras, three social rehabilitation board and care placements, three inpatient SUD treatment programs, and two homeless shelters. The main barriers are limited housing, communication by telephone due to homelessness, SUD disorders, limited resources for undocumented clients, and trust issues stemming from mental health diagnosis. As the ECM is adjunct provider, consultation with treatment team is paramount for client care.

Most of the referrals are to improve client's engagement with their treatment teams (not making it to appointments) and/or are not stable. In this reporting, all new client referrals were to reduce hospital and Psychiatric Emergency Services (PES) encounters. The difficult to engage client is typically medication non-compliant and/or homeless with limited family/social support. Use of culturally appropriate community agencies (e.g., faith-based, California Clubhouse, Pride Center, etc.) has helped support recovery when limited financial and family support exists. Assisting clients with task activities such as obtaining cell phone, assistance to coordinated entry, and other community resources improves client outcomes through building a working rapport and trust with the Case Manager.

The Case Manager makes every attempt to meet clients in the community and assess for food insecurity, linkage to mental health services/primary care, In-Home Supportive Services (IHHS), and support their housing goals/needs. Engagement strategies used are home visits both scheduled and unscheduled, use of natural family support, case conference with outpatient community partners, and joint home visits with a member of the treatment team. The best outcomes for ECM clients exist when there is a warm handoff from their clinical treatment team and collaboration with valued community partners.

Successes

A recently housed client was not following up on medical treatment, unable to follow housing rules impacting his ability to remain housed, and minimally engaged with treatment team. The Case Manager supported the client to understand his barriers of avoiding medical care through motivation interviewing and de-stigmatizing rehabilitation. He was declining all medical treatment for his cancer and supportive services. Over 5 months period working with the client 3 hours weekly, he began attend all medical appointments for cancer treatment, completed cancer surgery, followed up with Vascular and Ophthalmologist as after cancer care. He allowed ECM to assist with linkage to IHSS for ongoing support to remain living independently. ECM provided psychoeducation regarding housing rule compliancy to remain housed. Client now reports that he feels "married" to the ECM as she provides direct and timely feedback such that he views ECM as family.

A female client was referred for linkage back to the treatment team. The client has severe alcohol history with seizures impacting her health and ability to remain housed. Initially, she was hard to engage unless seen in PES or the Emergency Department (ED). ECM provide client

support to address depression, consider residential treatment, and did attend after several months or engagement. Upon completion of a 4-month residential treatment program, client was discharged home without notice and relapsed within 24 hours. She has hospitalized for seizure, stroke and embolism the next day. Leveraging the relationship, the ECM was able to support the clients' recovery, provide SUD education, and obtain IHSS. The Case Manager referred client to grief and outpatient SUD groups. Client has remained sober for past 8 months, no hospitalizations for past 7 months, follows up with medical appointments, remains living independently, is engaged in treatment, and seen weekly.

Challenges

The current barrier of not being fully staffed per the contract of 50 hours limits the number of clients being served. Mateo Lodge has referred task-oriented referrals to other programs and remain focused on the more severe and intense cases needing support over a year or two period. Staff are mindful of safety concerns and are unable to accept some referrals that may need a male provider only. A new rehabilitation group has been initiated on-site to teach/educate clients on the use of cell phones and technology to improve communication and attendance with providers.

HOUSING SUPPORTS

FSP SUPPORTED HOUSING (TAY)

The FSP Supported Housing Program for Transition-Age Youth (TAY) provides housing supports, housing and property management for up to thirty (30) TAY ages 18-25 and emancipated minors ages 16-18, in various sites, units in scattered sites, assisted living, board and care and locations throughout San Mateo County. The housing services were provided by Mental Health Association to Edgewood's TAY "Turning Point" FSP. The Mental Health Association offers integrated housing and support services geared toward achieving maximum levels of residential stability and improved health outcomes for TAY. Services provided include:

- Locate and obtain needed units of housing.
- Ensure that leased housing remains in clean, safe, and habitable condition.
- Collaborate on a regular basis with the FSP provider.
- Utilize creative, harm reduction-based techniques beyond standard property management practices and activities.
- Manage relationship with property owners including timely payment of rent, monitoring and enforcement of lease provisions, and problem solving.
- Occupational Therapist services to support the TAY resident.

Program Impact

TAY Supported Housing	FY 2021-22
Total clients served	8
Total cost per client	$51,166

Client demographics and outcomes are those of Edgewood's Comprehensive FSP program for TAY listed above. Mental Health Association (MHA) is also able to provide ongoing support to youth as needed, once they end FSP services, through their Support and Advocacy for Young Adults in Transition (SAYAT) program, which offers intensive case management and support services to facilitate successful independent living.

ADULT/OLDER ADULT HOUSING

Belmont Apartments: Of the 24 resident units, 8 formerly homeless adults living with serious mental illness (SMI) and substance use disorders (SUD) are original tenants, having moved in when the project opened more than 16 years ago. The eligibility for Belmont Apartments did not and does not include an MHSA eligibility designation, however at least 75% of current residents would be so designated if needed.

Cedar Street Apartments: Of the 14 residents' units, 6 formerly homeless adults living with SMI and SUD are original tenants, having moved in when the project opened more than 10 years ago. Of the 14 units, 5 are designated MHSA units. However, 10 current tenants were officially designated as MHSA eligible.

Since opening there has been a number of residents with complex medical conditions including a resident who was told she had less than 6 months to live. The Registered Nurse (RN) and nursing staff worked closely with her, she was provided a fully handicap accessible unit, and she was connected to other support services both inside and outside the apartment, including food delivery. As a result, her lifespan was extended by 5 years during which time staff were also able to connect her to her family and at the end of her life, her family was making regular visits. There is currently a resident who is close to end-stage Parkinson's disease. He is an original tenant who resided on the second floor. Upon diagnosis staff were able to move him to a handicap adaptable/accessible first floor unit, trading with another resident. He continues to receive assistance from Mental Health Association (MHA) Case Management, RN and Occupational Therapist (OT), has an In-Home Supportive Services (IHHS) provider and is fully supported by other residents who help him shop, bring him meals they prepare for him, and offer to bring him to the community room for activities. He truly is part of a caring community.

Waverly Place Apartments: Of the 15 resident units, 10 formerly chronically homeless adults living with SMI and SUD are original tenants, having moved in when the project opened more than 4 years ago. All units are designated as MHSA units. Several residents have already successfully lived at Waverly Place Apartments longer than they have lived anywhere else as

adults. Two residents have fairly significant medical conditions and are working with MHA's RN and OTs to ensure they receive the care they need as well as to aid in making and keeping medical appointments.

Challenges

Belmont and Cedar Street Apartments: COVID created the greatest challenge for both staff and residents. For those clients who had been employed, their work ended, and resulted in long period of inactivity. For the better part of two years, MHA staff were the only in-person people residents were seeing, and safety protocols made it even that more difficult. Staff were advised not to enter tenant units unless absolutely necessary and to meet one-on-one in the community room, rather than in apartments. This also meant that community rooms were closed for most community building activities. MHA is now having to repair some of the interpersonal damage that resulted. As a result of the tenants' treatment team staff moving to remote work, tenants found it much easier to disconnect from services which resulted in not taking medications, not seeing a professional for treatment, and for a number of individuals, having their episode with County BHRS closed due to not being seen or attending appointments. It is a major lift to try to repair those relationships as well.

Waverly Place Apartments: Although Waverly opened two years prior to the COVID shutdowns, many of the residents, all of whom were chronically homeless, were still in early stages of treatment and recovery. When the shutdown occurred, many completely disconnected from services and increased their usage of substances, with resultant behavior issues and problems which challenged the entire community. Combining that with a moratorium on evictions also resulted in significant issues and problems for individuals in the Waverly Place community.

AUGMENTED BOARD AND CARES

The purpose of the 10 contracted Board and Cares (B&C) are to provide supported living environments for clients with severe mental illness (SMI). These placements are needed to afford SMI client's an opportunity to live in the community. There is one BHRS staff member that is the designated B&C Liaison. The B&C Liaison processes referrals to B&C, completes assessments, provides care coordination with the treatment team and any issues related to their placement, and oversees admissions to and discharges from BHRS contracted B&C.

The target population served are adults with severe mental illness that have completed a social rehabilitation program, are stepping down from a locked setting, or coming from the community. They are psychiatrically stable, compliant with medications and in need of a supported living environment. Clients are Health Plan of San Mateo members, and either have Social Security Administration or General Assistance benefits.

The B&C provides three meals a day, medication management which includes storing and administration of medications. They regularly collaborate with the client's treatment team and conservator (if there is one) about the client's progress and address any issues that impact the client's placement. The B&C Operators work in close collaboration with the BHRS B&C Liaison. The role of the B&C Liaison is to support the client's transition into the B&C, oversee and coordinate their care, and ensure they address issues that impact placement. The B&C Liaison develops and coordinates a training schedule for the B&C Operators. The training increases the B&C Operator's capacity to address the needs of the SMI clients in their care as well as fulfilling their Continuing Education requirements. In addition, they have been providing and facilitating a series of mental health groups for clients at the B&C facilities. Curriculums for these groups have included Seeking Safety, Illness and Recovery Management, Dual Diagnosis, and Wellness Recovery Action Plan (WRAP). Tablets were obtained through the use of MHSA funding, for the virtual mental health groups when the facilities were in shelter in place. This was a source of emotional and social support when in-person contact was not possible.

Program Impact

Board and Cares	FY 2021-22
Total clients served	97
Total cost per client	$2,993

Board and Cares promptly process referrals and screen them for appropriate level of care. When placements open, the B&C Liaison promptly links and prepares the referred client for transition to their placement. B&C's keep track of the referred clients and the barriers that impact placement. The B&C Liaison regularly contacts and coordinates with the B&C Operators, treatment team, and the conservator (if there is one) to address and meet the needs of the clients at the facilities.

B&C promptly process referrals and screen them for appropriate level of care. When placements open, the B&C Liaison promptly links and prepares the referred client for transition to their placement. B&C keeps track of the referred clients and the barriers that impact placement. The B&C Liaison regularly contacts and coordinates with the B&C Operators, treatment team, and the conservator (if a client has been designated one) to address and meet the needs of the clients at the facilities.

The BHRS contracted B&C facilities are specifically for clients that have mental illness and or co-occurring substance use issues. All clients placed at the B&C are connected to BHRS regional clinics or a Full-Service Partnership Program, and thus their psychiatric and medical needs are attended to. If they are determined to need higher level of mental health services, then appropriate steps are taken to access such services in a timely manner. The B&C Liaison is

regularly working with B&C Operators and the treatment team to assess whether clients are getting the appropriate level of care services and able to access the needed services.

Clients with substance abuse problems are appropriately referred to substance use disorder (SUD) programs. The B&C Operators are trained on the possibility of relapse and work with the client's treatment team and the B&C Liaison to develop a plan to support the client based on recovery principles. There is one B&C that is specialized in serving clients with substance use issues. Interventions are considered and implemented based on the Recovery Model. The training module for B&C Operators also include trainings around Recovery principles.

BHRS Clinicians offer recovery-oriented groups at different Board and Care facilities throughout the program. The groups have included Seeking Safety, Illness Management and Recovery, Wellness and Recovery Action Plan, and a Dual Diagnosis Group.

Successes

B&C has been working with Mary Jane and Michael Que, who operate Simple Living Care Home, since 2009. Simple Living is an all-Women's Residential Care Facility in San Mateo. Mary Jane and Michael Que offer consumers compassionate care in a home environment.

In October of 2021, Mary Jane and Michael were selected for Housing Hero Awards that were presented at the Board of Supervisor's Meeting for their exceptional service in providing consumers with Complex Co-Occurring issues with Permanent Supportive Housing and Care. Mary Jane and Michael take some of the most complex clients from locked settings, who are often conserved, with histories of multiple hospitalizations and locked placements. Both are very collaborative with the County Treatment Teams, Conservators, and the B&C Liaison. Out of all the facilities, Simple Living is known for their ability to retain consumers in housing.

Linda, who is a resident of Simple Living, has lived there since 2019. Linda is in a Lanterman Petris Short (LPS) Conservatorship and open to a Full-Service Partnership (FSP) team. Prior to coming to Simple Living, Linda was at a Social Rehab and Crisis Residential facilities after stepping down from a Locked placement. She has a long history of serious mental health challenges and interpersonal conflicts, especially with female peers. As a result, she has long struggled with maintaining at one placement or in the community for long periods of time. Linda says, "I consider Simple Living my home. I like it there because I can walk to things, and I get support." She attributes her stability to the care, support, and connection she experiences at Simple Living. Based on the history of struggling with female peers, it is a true testament to the impact of the relationships and home environment at Simple Living and the impact of her support system, that she is thriving at an all-female facility. Through the wonderful collaboration and compassionate care among all the parties involved: Mary Jane and Michael Que, FSP Treatment Team, Linda's Conservator, and B&C Liaison, they have been able to address issues early on before they become problems and empower Linda to own, maintain, and thrive in her recovery. This excellent care and coordination have allowed Linda to feel connected, get her needs met, and find a home at Simple Living.

Challenges

COVID-19 pandemic continues to be a challenge for the B&C facilities and the clients. B&C facilities struggle with the continuing pressures of State licensing around COVID guidelines and with clients who struggle with consistently complying with COVID guidelines, due to growing frustrations and sense of loss. In particular, older adult clients, who are most vulnerable, have been negatively impacted. Three facilities were not able to take new admissions due to the COVID-19 lockdown. In addition, one of the B&C facilities that had to go into quarantine due to a number of clients and staff who became sick with COVID-19, was an assisted living facility that provides care for older adults with mental health and medical challenges.

Additionally, the prolonged impact of the pandemic has affected the mental health well-being of clients. Due to limits on person to person contact and gatherings, many of the community groups/agencies and activities, social outlets, and mental health support groups are still not available in person. This has been very challenging and has caused much stress for some of the clients. For some, it has meant a change to a higher level of care placement and number of 30 day-notices. When any concerning issues arise, the B&C Liaison organizes and facilitates case conferences on a regular, continuous basis with all relevant parties such as treatment providers, conservator (if there is one), facility operator, hospital staff, and client, if possible, etc. to address and resolve these issues. Recovery and trauma-informed principles and interventions are used to address such mental health challenges. There continues to be an increase in case conferences due to the continuing stressors for the clients.

With the increase in vaccinations, there have been more in- person contact by treatment providers whether in the field or at the facility. In-person appointments with treatment providers may be offered as well as remote modes of contact such as Telehealth. Additionally, B&C has implemented three therapy groups in-person at the facilities, taking all precautions, to provide the needed services in a safe, supportive manner. B&C has attempted to provide virtual groups using tablets, but many of the clients struggled with such technology. As a result, in order to provide the necessary support needed, the programs have been providing in-person groups. Also peer mentoring services have been made available to all B&C clients, especially for those who are struggling and in need of peer support. As a result of making this service available, peer mentors have been instrumental in providing on-site, in-person support on a regular basis, which is a huge source of emotional support, connection, and social outlet. The B&C Liaison has continued to contact the B&C Operators weekly to check-in on how clients are doing, address any concerns in a timely manner, and make monthly in-person visits.

Lastly, a significant challenge has been the continuing closure of the B&C facilities. Due to retirement by B&C operators, two board and care facilities closed, Hillcrest and University Guest Home. This has had a significant impact on the number of available placements for clients and the loss of a home for the clients. As a result, BHRS provided an increase in funding support, incentives, resources for facility renovations to improve the quality of life at the facility for clients, valuable updates and information, and coordination for vaccination centers, community resources, etc. to B&C Operators. MHSA funds have been used to provide

incentives that were built into their existing contracts. The B&C Liaison also continues to assist in evaluating and coordinating the needs of the B&C facilities and clients. Lastly, BHRS continues to explore and develop strategies and opportunities for expansion and increasing placements for clients.

Demographics

	FY 2021-22		FY 2021-22
Age		**Primary Language**	
26-59	59%	English	74%
60+	41%	Spanish	19%
Race/Ethnicity		Tagalog	5%
Chinese	1%	Arabic	1%
Filipino	10%	Intersex	
Black/ African- American	10%	No	100%
White/Caucasian	49%	Gender Identity	
Latino/Mexican/Chicano	21%	Male/Man/ Cisgender	79%
Japanese	1%	Female/ Woman/ Cisgender Woman	21%
Another race/ethnicity	3%	Sexual Orientation	
Unknown	4%	Gay, lesbian, homosexual	2%
Sex assigned at birth		Straight or heterosexual	98%
Male	69%		
Female	31%		

GENERAL SYSTEM DEVELOPMENT (GSD)

General Systems Development (GSD) in San Mateo County has been primarily focused on supportive services for individuals with mental illness through integration of peer and family partners throughout the behavioral health system of care, and community peer run and peer focused wellness centers; system transformation strategies that support integration of services across various sectors impacting individuals with mental illness' lives including co-occurring substance use, dual diagnosis intellectual disability, criminal justice, child welfare, aging; and integrating evidence-base practice clinicians throughout the system.

CO-OCCURRING INTEGRATION

CO-OCCURRING CONTRACTS & STAFF

MHSA co-occurring funding support substance use providers and BHRS staff to support integration of substance use and mental health services. Additionally, two clinical consultants provide co-occurring capacity development trainings to BHRS staff and multiple agencies, consultation for complex co-occurring clients and system transformation support.

Program Impact

Clients served by Co-occurring Staff	FY 2021-22
Total clients served	311
Total cost per client*	$904

The clients served includes data from BHRS staff providing co-occurring services. The clinical contracted providers that support co-occurring capacity development to BHRS staff and contracts accomplished the following in FY 2021-22:

July 2021 – September 2021

- Training / TA:
  - CalAIM Screening and Transition Tools review and feedback
  - Root Cause Analysis – type review and re-start meeting with Palm Avenue Detox
  - Assisted in drafting Building Communities of Recovery (BCOR) and Peer Workforce Investment grant applications for Voices of Recovery
  - Drafted and presented AB541 and Tobacco Screening and Cessation best practices
  - Reviewed and provide feedback regarding DHCS Peer Support Specialist certification guidelines
- Strengthening BHRS Partnerships:
  - Recovery Provider engagement with the System of Care (MOUs w/ collaborative meetings): Sitike, HealthRight 360, Free At Last (FAL), StarVista, El Centro de Libertad, Project 90, BAART Programs, Hope House, Voices of Recovery (VOR), Our Common Ground (OCG), BHRS Integrated Medication Assisted Treatment (IMAT) program
- Care Coordination:
  - Perinatal meeting with BHRS staff regarding referrals, system of care and utilization
  - Implemented new detoxification services at StarVista (draft bed check, program policy guidelines)

October 2021 – December 2021

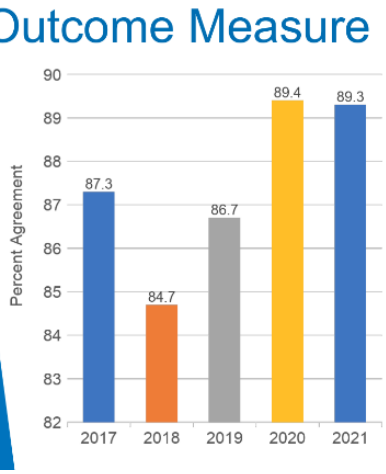
- Training / Technical Assistance:
  - Updated and present training: Drug Treatment and Psychopharmacology
  - Updated and present training: Treatment Planning

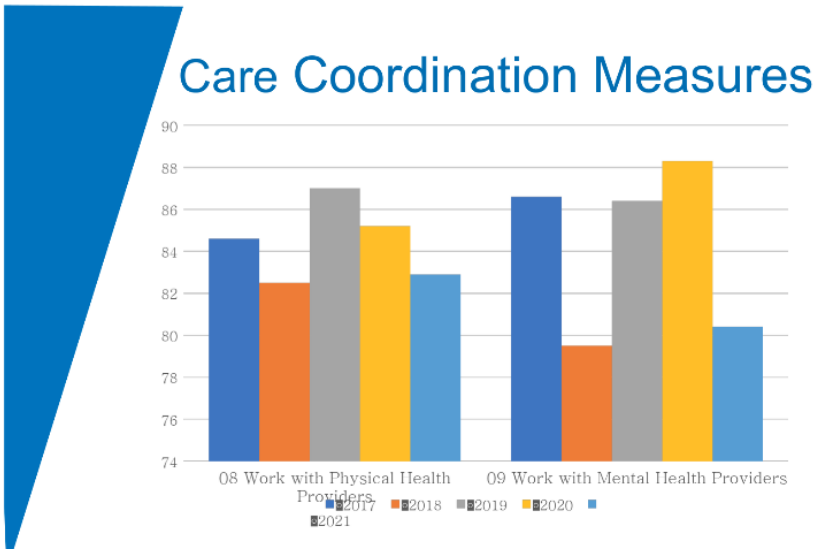
    - Presented Tobacco Screening, Treatment Referral, and Milieu Considerations
    - Presented of Smoking Cessation Training to StarVista
    - Presented of Smoking Cessation Training to OCG
- Strengthening BHRS Partnerships:
    - Recovery Provider engagement with the System of Care (MOUs w/ collaborative meetings): Hope House, FAL, StarVista, OCG
    - Meeting with The Latino Commission and VOR regarding monolingual Spanish service provision by VOR
- Care Coordination:
    - Assisted in implementing BCOR and Peer Workforce Investment training requirements for VOR
    - Consulted with Clarise Blanchard, Ph.D./StarVista regarding private hospital (Stanford and Kaiser) discharges to providers/BHRS (in regard to Sobering Station/Detox)

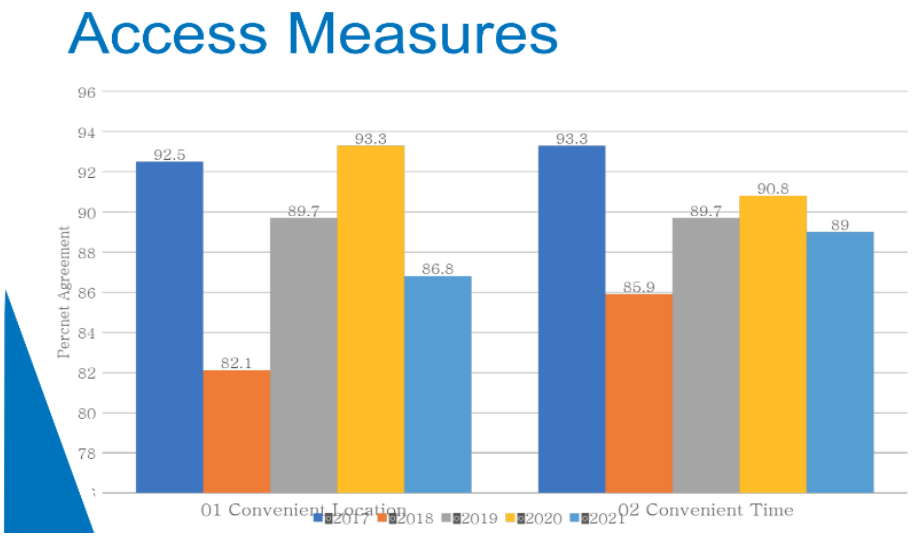
The Treatment Perception Survey (TPS) was administered to Alcohol and Other Drug (AOD) treatment programs during one week in September 2021 in all threshold languages. The TPS measures impact of services in 5 domain areas: Access, Quality, Outcomes, Care Coordination, General Satisfaction.

- 311 TPS completed (60% paper, 41% online, 0.6% automated phone survey)
- 22 contracted treatment programs participated
- 9% TPS surveys completed in Spanish, 90.9% in English
- 41.2% of respondents were White, 26.4% Latinx, 5.5% Asian, 10% Black and 3.5% Native Hawaiian and Pacific Islander (NHPI)
- 9% of respondents were 18-25 years of age, 31.2% 26-35 years of age, 27% 36-45, 14.8% 46-55 and 16.1% 56+
- 67.5% of respondents were male, 28.6% female, 1.3% transgender and 1.3% other gender identity

" As a direct result of the services I am receiving, I am better able to do the things I want to do."







Successes

Client quotes:

1. "I have found all the staff to be caring, hardworking, respectful and most are very professional. I have nothing but very positive things to say about everyone at HealthRight 360. Thank you for helping me at a time in my life when no one else would. You have all saved my life."
2. "They didn't judge me, got me into services. Quickly. I wouldn't change anything."
3. "The program helped me to become grateful and happy. I was so tired of being tired."
4. "Es un programa muy bueno estoy muy contenta que he venido a este programa. Me ha ayudado mucho y les agradezco mucho por su ayuda."

CO-OCCURRING YOUTH RESIDENTIAL

There is an ongoing need for youth residential treatment in San Mateo County. Because of a range of licensing issues, the identified provider for this service has not been available. BHRS continues to pay for single case agreements with other providers.

For both sustainability and quality reasons, Bay Area Counties began exploring a Participation Agreement with CalMHSA, who would serve as the fiscal sponsor, for to dedicated youth residential capacity services through Advent Youth Ministries. Counties would share the cost/risks of dedicated beds based on utilization.

Challenges

- Advent is the only Drug Medi-Cal certified facility in the Bay Area and at great risk of closure. For "both quality of care and fiscal stability" concerns counties will not be moving forward with this contract.
- Since there is currently no Medi-Cal revenue, BHRS is making private provider placements. Spending on Youth Residentials has been variable and expensive single case agreements with out-of-county programs.
- Bay Area SUD Counties continue to explore a collaborative approach with CalMHSA to support Youth Residential services.

RECOVERY SUPPORT SERVICES

Voices of Recovery San Mateo County (VORSMC) is the only peer-run recovery services organization in San Mateo County for individuals seeking and maintaining long-term recovery. They envision a world in which recovery from addiction is both a commonplace and a celebrated reality, a world in which the entire spectrum of effective prevention, treatment and recovery support services are available and accessible to all who might benefit. Established in 2009, VORSMC's mission is to create peer-led opportunities for education, wellness, advocacy, and support services for individuals in or in need of long-term recovery from alcohol and other drug addictions, equally sharing these opportunities with impacted families. Each year, they provide free direct services to over 500 unduplicated clients, including low-income, houseless, LGBTQIA+, Black, Indigenous People of Color (BIPOC), and justice-involved populations in San Mateo County. They have offices in Belmont and East Palo Alto. VORSMC is a Black-Woman-led organization with a diverse staff–with whom have lived experience of recovering from addiction. They utilize the Wellness Recovery Action Plan (WRAP) program, a peer-led, evidence-based practice, to structure recovery services and support for the County's most vulnerable populations.

The agency works to prevent relapse, sustain long-term recovery, and support family members affected by addiction. The agency also helps develop employment opportunities and engages in community outreach to promote addiction-free lifestyles. VORSMC's WRAP program is an

evidence-based, peer-led practice that has been nationally recognized by Substance Abuse and Mental Health Services Administration (SAMHSA) as an effective way to help marginalized populations, including people of color and persons reentering the community from incarcerated settings, maintain their recovery from addiction and mental health issues.

WRAP is based on the premise that everyone is an expert on self, and there is no judgment. People sharing their lived experience within the group reduces stigma's effect by helping others disclose their experiences with mental illness, treatment and or recovery. The program understands that self- stigma has a damaging effect on the lives of people, and although medical perspectives might discourage patients from identifying with their illness, at WRAP they encourage public disclosure which promotes empowerment and reduces self-stigma.

Program Impact

Voices of Recovery	FY 2021-22
Total clients served	209
Total cost per client*	$788

VORSMC program is mostly offered at partner organizations across the county. Thus, directly accessing their target population. During the COVID-19 pandemic, all groups and communication are offered virtually, through Zoom, website, Facebook, YouTube, and other media avenues. This access allows improvement in the access and linkages to the populations they cannot serve before the pandemic. Virtual presence allows them to provide convenient, accessible, and acceptable services in a culturally appropriate setting.

VORSMC offer groups designed and implemented in ways that reduce and circumvent stigma, including self-stigma and discrimination related to being labeled as an alcoholic/addict or diagnosed with a mental illness, having a mental illness, or seeking mental health services, and making services accessible, welcoming, and positive having groups facilitated by peers with lived experience. VORSMC facilitators use non-stigmatizing and non-discriminatory approaches by sharing personal stories that are positive factual messages and tools they have learned to use to focus on recovery, wellness, and resilience, using culturally appropriate language, practices, and promoting positive attitudes.

VORSMC provides free services to all individuals, which helps to increase the number of individuals seeking service. They also provide mentorship from WRAP facilitators, referral to residential treatment providers, and public health services. The online resource presence helps individuals access other services; housing, transportation assistance, referrals to health clinics to address chronic conditions, and other educational, social, and recovery services, as identified by participants in their groups.

Disparities in access to care is a significant issue with the peers that VORSMC service. Most of the participants do not have insurance and have difficulties seeking care, especially during the pandemic, because they lack the technology for use. VORSMC aids in reducing disparities by

allowing the use of computers and aiding with application processes. VORSMC's partnership with the different minority initiatives helps increase awareness of racial disparities and advocate for more minority physicians and therapists in San Mateo County. VORSMC prioritizes the elimination of racial and ethnic health disparities as a top priority.

VORSMC implements recovery principles by adhering to the 10 core principles of recovery.

- Self-direction: WRAP participants are encouraged and guided to set their path to recovery.
- Individualized and person-centered: WRAP helps their participants to set their own individualized recovery pathway based on their own strengths, needs, preferences, experiences, and cultural backgrounds.
- Empowerment: WRAP participants are empowered to choose among options and participate in all decisions that affect them.
- Holistic: WRAP has a very holistic approach to a participant's recovery and helps participants focus on their life, including mind, body, spirit, and community.
- Nonlinear: WRAP sets a Non-linear tone to discussing and approaching recovery by emphasizing the importance of continual growth despite occasional setbacks.
- Strengths-based: WRAP helps participants think about their own strengths and empowers them to use their strengths in their recovery journey.
- Peer support: In an 8-week WRAP program, the participants receive mentorship from their WRAP facilitators and continue to receive peer support for up to one year after completion of the program. While in these groups, peer coordinators offer support in accessing services and help create links to housing, transportation assistance, referrals to health clinics to address chronic conditions, and other educational, social, and recovery services, as identified by participants in their groups.
- Respect: The WRAP groups are facilitated by facilitators to provide participants with a space to be themselves and positively share their experiences.
- Responsibility: The program emphasizes the importance of personal responsibility in approaching one's recovery.
- Hope: This is the central to WRAP programs, and the majority of the participants in the post-completion survey, agree they have hope after completing the WRAP groups.

Successes

VORSMC continues to provide intervention in many ways, due to the pandemic and the continued restrictions they are offering peers virtual support with support groups and peer mentoring. With the increase in Peers returning to use substances and alcohol with no help and support, they are able to help these Peers enter Detox and residential treatment centers and they have returned to the recovery community. Residential program stay continues to be less and less leaving Peers looking for a safe place. Currently, they are supporting them virtually and hoping to get back to in-person support soon.

The Unedited Success Stories:

"My name is **Jessica Britto,** I am a strong-minded woman who has battled with addiction for many years. Because of difficult losses in my life, I chose to go down the rabbit hole of using and abusing drugs. I first experienced recovery as a child at the old Alano house, watching my own mother struggle to keep attending her meetings and lean on her support. I had not expected myself to follow in her footsteps, but I did. I have gone in and out of jails and different recovery organizations only to find myself back in the chaos of addiction.

Finding WRAP through Voices of Recovery changed the way I looked at myself and my actions. In some ways, it feels like the missing piece to the puzzle. I entered a group of peers who had gone through and shared things to which I can relate. The tools I have learned by walking through the material has helped me recognize more about my internal and external behaviors and how to replace my negative actions. This is something that is essential to staying in recovery for me. Today, I am more hopeful than ever and have found I can lean on others. I am doing right for myself by discovering who I truly am and what works for me. I also owe many thanks to recovery and all who crossed my path along the way."

"My name is **Veronica Antonelli,** and I am a person in long-term recovery from drug and alcohol addiction. Today, I have over a year of clean time and am still pushing forward. Like everyone, I have suffered some tragedies in my life that sent me into a tailspin, and I found myself using substances as a crutch to get through day-to-day life. I had reached the peak of my addiction towards the end of high school, and it got worse from there. I was involved in a fatal car accident that quickly consumed my life. Dealing with incarceration, addiction, loss, the court system, and parole left me in a state of self-loathing I couldn't break on my own.

There came a pivotal point in my life when I was told, by my parole officer, I had to get clean before I violated my orders and went to prison. I went through the motions of going to detox and getting into a residential treatment program, where I was able to learn a somewhat healthy routine and break bad behaviors I relied on in my addiction. Although there was still more for me to learn about myself, I felt pretty good about the direction I was going.

Continuing my journey in recovery led me to volunteer and become a staff member at Voices of Recovery San Mateo County. In the field of recovery, I have been able to learn and relay knowledge that has been crucial for my personal wellness. This year has been extremely different from difficult years before. I am grateful to have the support from my team and the community who participates in groups with us. I have been able to construct a wellness recovery action plan that fits the changes to my routine and helps me get in tune with myself

on a deeper level. I feel very fortunate to have these tools in my life today, because at one point the balance and hope that I have now felt far out of reach."

Challenges

VORSMC continues to service a large community of Hispanic, monolingual Spanish residents and they have the challenge of translating Spanish material for the community. Space continues to be a challenge for VORSMC, as they lack adequate space to provide support for the recovery community. Another challenge it the lack of capacity to develop new trainings, and hold educational trainings for staff, volunteers, and the community due to inadequate equipment and space.

Demographics

	FY 2021-22		FY 2021-22
Primary Language		**Sex Assigned at Birth**	
English	67%	Male	76%
Spanish	33%	Female	21%
Age		**Gender Identity**	
0-15	0%	Male/Man/Cisgender	76%
16-25	23%	Female/Woman/Cisgender Woman	21%
26-59	72%	Decline to state	3%
60+	5%	Sexual Orientation	
Race/Ethnicity		Gay, lesbian, homosexual	5%
Asian	7%	Straight or heterosexual	85%
Black/African-American	18%	Bisexual	7%
White/Caucasian	28%	Queer	1%
Mexican/Chicano/Hispanic/Latinx	37%	Another sexual orientation	2%
Arab/ Middle Eastern	1%		
Another race/ethnicity	9%		

OLDER ADULT SYSTEM OF CARE

OLDER ADULT SYSTEM OF INTEGRATED SERVICE (OASIS)

The Older Adult System of Integrated Service (OASIS) Program purpose is to provide outpatient field based mental health services for home-bound elderly individuals with severe mental illness (SMI) and/or Substance Use Disorder (SUD), co-occurring medical diagnoses and

functional limitations. The program assists elderly individuals to live in the community independently with improved quality of their lives. The targeted population served is the elderly ages 60+ with severe mental illness and co-occurring diagnosis due to mobility issues and functional limitations. Primary program activities provided include interventions such as psychiatric assessment and treatment, psychiatric medication evaluation and on-going monitoring, clinical case management, rehabilitation counseling, individual or family therapy, peer support, psychoeducation, and collateral support with other community services.

Program Impact

OASIS	FY 2021-22
Total clients served	175
Total cost per client	$5,798

During this FY 2021-22, the program has improved timely access to clients who meet minimum requirements by being able to connect them with services within 3 days of referral. This approach has allowed clients to be shifted onto a case manager's caseload and met within 2 weeks. From there, if a client needs medications and needs to meet with a psychiatrist, they can be connected within an additional 2 weeks. This improvement makes the process as streamlined as possible so clients can be fully connected to services within 2-4 weeks. Prior to this year, it had taken up to a month for clients to be fully connected to services. The improvement in timely access has been a result of clients being connected to mental health services and health services to create a better sense of well-being and health.

The target population of the program is an underserved, often forgotten population. The OASIS team works to provide case management, therapy, psychiatry, access to medical care, transportation services, access to food, or community resources to help clients gain a healthier life. For example, the program has recently connected with Project Sentinel, a service that provides housing advocacy and solutions. Project Sentinel sees clients who are pushed out of their housing due to their age because of cognitive decline or an SMI diagnosis, and they can provide legal aid and consultation to get clients back to their prior housing arrangement. OASIS staff are also involved with county health and equity initiatives that support senior well-being.

As previously mentioned, the program is revamping the referral process to make it more streamlined and ensure that clients are receiving timely access to care, including primary care for co-occurring health issues. The OASIS team also attends monthly meetings with the Ron Robinson Clinic, which specializes in geriatric care. In these meetings, the team can collaborate with providers and ensure that they are referring clients to the team as soon as they start to see someone with an SMI diagnosis.

The program has incorporated strategies to reduce disparities. For example, the program reaches out to other providers, such as Ron Robinson, to make sure clients are getting medical care, which is especially important with the target population as they are aging. Staff also prioritize connecting clients to board and care facilities for when they are not able to live in the

home setting. Board and care facilities are senior living facilities that care for residents who need assistance but do not require ongoing skilled nursing care.

Connecting to coastal community-based organizations and health care centers such as Puente Clinic has allowed the program to service clients who live alone and may not have the resources they might get if they lived further inland. The program has been outreaching to several community resources as well as resources within BHRS to ensure it is limiting the possibility for disparities in access to care toward older adult populations who are non-ambulatory, have mental health barriers, and are at times unable to care for themselves due to complex medical issues. Home visits have also been essential in reducing disparities in access to care, as this allows staff to assess clients' daily needs such as access to food. Home visits and providing in-person services were especially critical during the pandemic, as most of the older adults did not have the technology or ability to connect with their providers via telehealth.

The program has aimed to implement recovery principles this year. One example of this within the OASIS program is a case manager who provides in-person support with therapy case management. In addition to this, they recognized a client's needs surrounding hoarding. Staff reached out to a specialized unit within the community that helps declutter to reduce the risk of client injury and helps work through trauma associated with hoarding. Another example is the OASIS team's cultural sensitivity. The program staff is culturally diverse in ways that make clients feel seen and heard as they are going through their process and therapeutic recovery. Other ways that the program implements recovery principles include collaborating with client families for support, advocating to keep housing placements, and connecting clients to substance use resources.

Successes

One success the program has experienced this year has been connecting clients to their medical care, especially with Ron Robinson Senior Care Center, which handles geriatric cases in San Mateo County. Program staff have also been especially successful at advocating for clients in medical care settings and assisting clients in getting timely COVID-19 tests and vaccinations. The OASIS program is proud of the fact that it has continued to provide services in person despite the COVID-19 pandemic. The in-person care that OASIS staff provide allows them to report on a client's health more quickly and consistently than phone and telehealth visits, especially in older populations. These in-person evaluations and assessments have been beneficial to clients' health and well-being.

Client Success Stories:
Client EB is an 84-year-old African American female diagnosed with anxiety disorder. She's been in treatment with OASIS for medication management/therapy and has been very stable. Compliant with treatment, she sees this writer and her psychiatrist regularly and takes medication as directed. Client was diagnosed with diabetes, hypertension, fall risk (uses walker/cane), chronic pain in back and knees, asthma, and hyperlipidemia. Client is regularly

treated by her primary care provider and various specialists. She is conscientious about her physical health and treatment; compliant with appointments and taking medication as directed. EB lives in a well-maintained Housing and Urban Development (HUD) low-income subsidized apartment in San Mateo. Client has an attentive In-Home Supportive Services (IHSS) provider who is also a family friend. Within the past year, she has lost several close friends and extended family members. She felt depressed following the losses and has had difficulty accepting her chronic illnesses will not improve. She states her faith sustains her. Client is the matriarch of her supportive extended family. She has strong ties to her church and is considered an elder, attending services/Bible study regularly and engaging in prayer. EB says she is fortunate to have an African American therapist. She believes shared cultural experiences strengthen the therapeutic relationship.

Client DC is a 61-year-old Caucasian female with a lengthy history of mental illness and treatment. She is unemployed and receiving Social Security Disability Insurance (SSDI). Client received case management/counseling services from OASIS therapist since 9/2019, declining psychiatric services/medication, to cope with symptoms of Post-Traumatic Stress Disorder (PTSD) and anxiety. She has significant domestic violence abuse and childhood emotional/sexual abuse history. Her medical diagnoses include chronic vertigo, chronic ear/sinus infections, Chronic Obstructive Pulmonary Disease (COPD), and Inflammatory Bowel Syndrome (IBS).

In 2019, client was living in termed-out low-income supervised housing unit: renting a room in a house after being homeless for 3 years. She felt preyed upon and unsafe there. Case Manager (CM) linked client with Brilliant Corners associate and collaborated with San Mateo County Housing Authority to secure a quality one-bedroom apartment in a desirable complex in Burlingame. For the past 2 years, client has thrived enjoying living alone in a stable environment. She continues to engage in therapy as she faces challenges with MH symptoms and chronic medical issues. CM collaborated with Upward Health, Landmark Health, Health Plan of San Mateo (HPSM), In-Home Supportive Services (IHSS), Adult Services, Housing Authority, Brilliant Corners, Mental Health Association, and San Mateo Sheriff's Department.

Challenges

One of the biggest challenges the program faces is a lack of board and care placements, which often leaves clients with limited housing options. Another challenge is the passing of clients, which takes a physical and emotional toll on staff. One way the county can support this challenge is giving the program the ability to bring in trauma-informed providers, trainings, and supports to make sure staff feel like they are seen, heard, and supported.

Staffing challenges have also put a burden on existing staff. Within the program, OASIS staff have been working through staff transitions and looking to find time to connect as a team through self-care activities or a retreat.

Demographics

Age	%	Race	%
0–15	0.0	White/Caucasian	37.7
16–25	0.0	Other	17.1
26–59	1.1	Chinese	9.1
60+	98.9	Black	5.1
Primary language	**%**	Multiple	2.9
English	68.6	Filipino	1.7
Spanish	13.1	American Native	1.1
Mandarin	7.4	Japanese	1.1
Cantonese	4.6	Asian Indian	0.6
Russian	1.1	Korean	0.6
Tagalog	1.1	Unknown / Not Reported	22.9
Polish	0.6	**Ethnicity**	**%**
Other Chinese Language	0.6	Hispanic or Latino	20.6
Unknown / Not Reported	2.9	Not Hispanic or Latino	53.7
Sex assigned at birth	**%**	Unknown / Not Reported	25.7
Female	73.7		
Male	26.3		
Sexual orientation	**%**		
Straight or heterosexual	28.0		
Decline to state	1.7		
Unknown / Not Reported	70.3		

PEER COUNSELING

Peer Counseling, formerly Senior Peer Counseling, from the Peninsula Family Service (50% CSS, 50% PEI) is comprised of specially-trained volunteer counselors, more than 100 in total, to provide weekly visits to older adults to help manage transitions and life changes such as health concerns, mobility issues, caregiver needs, and grief. Special care is taken to connect participants with someone who shares similar life-experiences and perspectives, with support offered in languages such as English, Mandarin, Cantonese, Spanish, and Tagalog, and to participants who identify as LGBTQ+. Peer Counseling provides peer support by trained and supervised older adult volunteers. The program serves older adults, 55 years and older, who reside in San Mateo County who are isolated, depressed, and anxious. The program targets underserved older adult population who may be monolingual in Spanish, Mandarin, Cantonese, Tagalog and to participants who identify as LGBTQ+.

In FY 2021-22, the Peer Counseling served 539 unique clients in San Mateo County through their one-on-one peer counseling and group sessions.

Program outcomes are included in the PEI section of this report.

Criminal Justice Integration

PATHWAYS COURT MENTAL HEALTH PROGRAM + HOUSING

Pathways is a partnership of the San Mateo County Superior Court, Probation Department, District Attorney, Private Defender Program, Sheriff's Office, Correctional Health, National Alliance on Mental Illness, and Behavioral Health and Recovery Services. Pathways is an alternative path through the criminal justice system for those with serious mental illness. Pathways participants may have a co-occurring substance use disorder as long as a functionally impairing major mental illness is also present. The criteria for eligibility include statutory eligibility for probation, San Mateo County residency, diagnosis of a functionally impairing major mental illness, voluntary agreement to participate, and age 18 or older.
Primary program activities include intensive case management (treatment and recovery plan services, medication linkage, supportive housing services, treatment and recovery support for co-occurring mental health/substance use, psycho-educational/recovery services, service coordination including assistance/linkage with health care services, peer support/mentoring, family education and support) and intensive monitoring and probation supervision.

During this reporting period, Pathways was staffed by four case managers, two full-time clinicians, and one mental health program specialist who helped facilitate psychoeducational, support, and rehabilitation skills groups: Pathways Clubhouse is socialization and skills group co-facilitated by the Pathways lead clinician and peer support worker. This weekly group includes socialization activities and group outings with a focus on increased communication skills and symptom reduction through peer support. Pathways Men and Women's process-oriented groups also meet weekly for participants to further reinforce natural support systems and coping skills. Lastly, Pathways runs a Cognitive Behavioral Therapy group facilitated by two clinicians. This group utilizes evidence-based cognitive behavioral therapy interventions from the model Thinking for a Change, a manualized intervention that concentrates on cognitive interventions and criminogenic thought processes.

Pathways generally hosts annual events that include members of the community, program alumni, current clients, and staff, but much of FY 2021-22 continued to be overshadowed by the COVID-19 pandemic. As such, Pathways has maintained a sense of community through small and safe events. In response to the pandemic, Pathways has leveraged technology and virtual platforms, such as Teams to host virtual game sessions for the Clubhouse group, as well as engaging in socially distanced outings when advisable by county guidelines. Despite having to

cancel larger events, Pathways remain in coordination with community partners including Correctional Health Services, National Alliance on Mental Illness, Sheriff's Office, Private Defender Program, the District Attorney's office, and community alcohol and drug treatment providers. After two years of canceling the annual Pathways picnic, Pathways was able to host the picnic in May 2022.

Program Impact

Pathways	FY 2021-22
Total clients served	47
Total cost per client	$7,360

Most Pathways clients represent traditionally underserved populations; all have experience with the criminal justice system and a mental health diagnosis. Pathways has four case managers, who work with clients individually and intensively to ensure that they are connected in a timely manner with a warm handoff to needed services. Each clinician develops an individually driven treatment plan to address client-specific needs that are sensitive to history of minimal access to resources. Services accessed include public health services (e.g., Medi-Cal enrollment, benefits applications, linkage with a regional mental health clinic and primary care provider) as well as additional services with partner programs based on individual needs (e.g., chemical dependency treatment, housing agencies). Pathways' clinicians also provide direct clinical services to all clients, including group and individual therapy and crisis management, to ensure low barriers to access needed care. Pathways also proactively works to combat stigma and discrimination, particularly about mental health diagnoses and difficulties. Pathways encourages participants to speak openly about their experiences and partners with organizations such as the National Alliance on Mental Illness (NAMI) to participate in activities such as the annual NAMI awareness walk, mental health month, and suicide prevention initiatives. Further, Pathways utilizes the peer support worker model to reinforce the recovery and human-centered approach to treatment.

In this reporting period, all 47 of current clients were able to reduce the duration and severity of mental illness through their active participation in Pathways support and treatment groups as well as through intensive case management. Specifically, many clients also addressed concrete negative outcomes that result from untreated mental illness:

- Pathways is an alternative to incarceration, meaning that all enrolled clients are in Pathways and thus able to avoid incarceration by obtaining mental health treatment.
- Over the reporting period, 13 clients were booked into custody on probation violations. 5 of those were readmitted without future violations, and 8 were excluded from the program

- 15 clients newly obtained stable housing; of those, 1 obtained permanent housing vouchers, 11 joined sober living environment homes, 2 could afford their own place, and 1 is in social rehabilitation or board and care settings
- 9 clients newly obtained employment

Successes

The support, Pathways, provides far extends to not only being on probation and successfully dismissing a case, but also helping clients grow on their positive attributes. In this past year, John (name changed to maintain confidentiality), had gone through many strides to succeed and graduate Pathways. John entered this program minimally engaged due to his severe mental health symptoms. He was mostly non-verbal and avoidant of meaningful contact with others. Despite this, he was persistent and strived to maintain medication and treatment compliance and slowly started to show his true self. He eventually started communicating verbally – he was quite articulate and extremely intelligent. John also returned to school, majoring in computer engineering, graduated, and successfully found stable employment. Upon graduation, John was mentally and financially stable, and reunified with his family, whom he thought he would never see again.

Another client, Georgia (name changed to maintain confidentiality), has been on the road to success and heading towards graduation. Georgia has struggled with severe mental illness most of her life, leaving her in unhealthy and unstable situations. This past year, she went through transitions of having a newborn child, moving to a family shelter, and then awarded an emergency housing voucher. She has had no violations and is pursuing her General Education Degree (GED) now.

Challenges

Restrictions related to the pandemic have been the primary area impacting client care and timely access to treatment. Specifically, clients needing access to Residential Treatment Programs (RTPs) have encountered delayed admissions, due to RTPs operating at half capacity. While the county is able to provide temporary housing to ensure the client quarantines appropriately, there is little support available to help a client trying to remain sober doing that time. Pathways has found that many clients ultimately relapse during their quarantine period, resulting in an increase in rates of rearrest and hospitalization.

Demographics

	FY 2021-22
Age	
16-25	6.4%
26-59	91.5%

60+	2.1%
Primary Language Spoken	
English	96%
Spanish	4.%
Russian	0%
Cantonese	0%
Tagalog	0%
Unknown/Not Reported	0%
Sexual Orientation	
Gay, lesbian, homosexual	6%
Straight or heterosexual	79%
Bisexual	2%
Decline to state	13%
Veteran	
Yes	0%
No	98%
Unknown/Not Reported	2%

PATHWAYS, CO-OCCURRING HOUSING SERVICES

Pathways still has 2 contracted beds at Maple Street Shelter. 1 is dedicated for male identified clients, and 1 for female identified clients. A challenge experienced with housing clients at this shelter is due to COVID. The facility completely shuts down and does not allow new admissions until they are COVID-free. This can take about two weeks to 8 weeks.

- 1 client occupied male beds
- 0 clients occupied female beds

GIRLS PROGRAM

The Gaining Independence and Reclaiming Lives Successfully (GIRLS) Program was providing high-level behavioral health services to youth with co-occurring mental health and substance use issues at Camp Kemp in San Mateo County. The program ended as of FY 2021-22 due to decreased client census. BHRS Child and Youth Services staff continue to support the co-occurring case management, individual and family therapy needs of the youth clients.

OTHER SYSTEM DEVELOPMENT

Other System Development efforts help improve the behavioral health service delivery system across various sectors and areas of focus.

PRENATAL-TO-THREE (CHILD WELFARE PROGRAM)

The purpose of the San Mateo County (SMC) Prenatal to Three Initiative is to provide parents or caregivers of children through age 5 as well as pregnant mothers with mental health treatment and other social needs resources that promote their well-being. Specifically, staff serve women eligible for Medi-Cal with serious mental illness (SMI) who require psychotherapy and medication management of their symptoms. In addition, staff provide services designed to support early infant development and improve parent-child relationships in situations in which physical, developmental, or social risk factors are present. The initiative encompasses three programs with unique provider pools and referral workflows:

1. The **Prenatal to Three program** coordinates mental health treatment and psychoeducation for pregnant women, postpartum women up to one year after childbirth, and adult caregivers of children through age five who choose to receive program services after being referred by San Mateo County Family Health Services (FHS) division pediatricians, their primary care physician or Obstetricians and Gynecologists (OB/GYN), or BHRS Access Call Center staff, or after completing the self-referral process.
2. In contrast, the **Partners for Safe and Healthy Children program** manages mental health treatment and psychoeducation for pregnant women or adult caregivers with children through age five whose participation in the program has been mandated by the judge presiding over a Child Protective Services (CPS) case.
3. Finally, the **Prenatal to Three Teen Parent program** serves pregnant teenagers, post-partum teenage mothers up to one year after childbirth, and children through age 5 with teenage mothers; beneficiaries are either required to participate in therapeutic activities per the terms of a CPS case ruling or choose to receive program services after being referred by a San Mateo County provider or completing the self-referral process.

Activities across these programs include conducting initial mental health assessments, which informs the creation of treatment plans; providing psychotherapy and psychoeducation to clients; and offering case management services, including referrals to psychiatrists, Alcohol and Other Drug (AOD) services treatment providers, and community-based organizations. While therapeutic interventions vary depending on the needs of the client, program clinicians commonly provide some form of Child-Parent Psychotherapy as well as specialized care for prenatal and postpartum clients. In addition, several program clinicians have been trained in the Neurosequential Model of Therapeutics (NMT) approach, Trauma-Informed Cognitive Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR) psychotherapy, occupational therapy, and infant massage.

All Prenatal to Three Initiative staff strive to provide trauma-informed care and linkages to resources that improve clients' overall quality of life. In addition to attending the CPS court case and coordinating referrals for any judge-mandated activities, which often include family therapy, parenting classes, or anger management sessions, Partners for Safe and Healthy Children Program staff conduct regular home visits and attend Child Family Teaming (CFT) events. Moreover, all clinicians rely on several assessment tools, including the Child and

Adolescent Needs and Strengths, the Ages and Stages Questionnaire, the Pediatric Symptom Checklist, and the Child Behavior Checklist to identify developmental areas that may have been affected by trauma. This, in turn, determines the interventions that are recommended for a given child and/or their caregiver, which often includes play-based therapy for children through age 5, individual therapy for adults, and dyadic therapy for caregivers. Finally, program staff address unmet social needs by distributing free household items, such as diapers, or by connecting families with affordable housing support resources.

Program Impact

Child Welfare Partners	FY 2021-22
Total clients served	750
Total cost per client*	$944

The Prenatal to Three Initiative improves **timely access and linkages for underserved populations** by following procedures designed to expedite the closure of referral loops for Medi-Cal clients. Prenatal to Three program staff help the Health Plan of San Mateo comply with California's timely access requirement to ensure that enrollees receive mental health services within 2 weeks of the initial request, by making at least three phone-based contact attempts within 10 business days of receiving the referral and capturing those details in a Client Services Information (CSI) Assessment Record. If these actions are unsuccessful, staff send the referred client a letter explaining how they can begin receiving program services and listing other county-based resources. Partners for Safe and Healthy Children staff are tasked with meeting even more stringent timely access requirements. For CPS referrals categorized as urgent, staff strive to contact the referred individual within 24 hours, while non-crisis referrals from CPS are to be addressed within a 48-hour timeframe. When staff capacity constraints make it difficult to begin providing services within 48 hours of receipt of the referral, the most vulnerable clients—generally children between the ages of 0 and 5—are prioritized for an appointment with a clinician.

The Prenatal to Three Initiative helps **reduce the prevalence and severity of stigma** experienced by clients by providing psychoeducation during routine therapy sessions as well as special group-based sessions. In recognition of Mental Health Awareness Month, program staff hosted a group-based session for clients in May 2022 to discuss the stigma felt by pregnant and postpartum mothers who had experienced mental health issues. Staff shared information about medication management tools and arranged for a prior client to speak candidly about some of the mental health challenges she faced, and eventually overcame, with the support of program staff.

Moreover, the Prenatal to Three Initiative **reduces disparities in access to care** by tailoring service delivery methods to the needs of each client. Many Medi-Cal clients lack access to

reliable transportation, making it much more difficult for them to travel to clinicians' offices for mental health care. Program staff can remove this obstacle by offering to conduct home visits, or in cases in which safety or confidentiality is a concern, arranging to meet clients at a convenient location within their community. Program staff also coordinated with Child and Family Services (CFS) staff during the COVID-19 pandemic to minimize disruptions to clients' mental health treatment. Clients who did not own suitable technology received a free cell phone or laptop, allowing them to continue receiving therapeutic and psychiatric services through telehealth visits when it was too risky to conduct in-person.

Prenatal to Three Initiative staff regularly **increase the number of individuals receiving public health services** simply by connecting referred individuals to appropriate mental health services. However, over the last few years, program staff have also collaborated with community workers and public health nurses to boost COVID-19 vaccination uptake rates. Specifically, leadership directed program clinicians to collect data from clients about their vaccination status and address any misconceptions about the risks. For example, clinicians helped overcome some clients' resistance by assuring them that registering for a vaccination appointment would not result in their deportation or separation from their children.

Finally, program staff consistently **implement recovery principles** while caring for pregnant women and caregivers of children between 0 and 5. For example, program leaders have taken multiple steps to ensure that clients receive *culturally sensitive care.* Most significantly, supervisors have prioritized hiring bilingual staff, including up to 6 interns on an annual basis, to better serve the large number of clients who are monolingual Spanish-speaking. In addition, supervisors encourage clinicians to reflect on mandatory racial equity and diversity trainings, asking volunteers during staff meetings to share their thoughts about how to implement what they learned in the trainings in future interactions with clients. Program staff also *facilitate the involvement of community members* by organizing Café Con Padres (Coffee with Parents), which function as informal support groups. Clients are paired with other parents to discuss their lived experiences over coffee and donuts. Finally, program staff *promote care integration across providers* by pursuing opportunities to collaborate with BHRS staff from other divisions and representatives of outside community agencies. For example, many Prenatal to Three Initiative therapists attend clients' appointments with a psychiatrist to provide emotional support. Clients commonly express fears that certain medications may not be appropriate to take during their pregnancy, and the reassurance provided by their therapist has been instrumental.

Successes

Program leadership highlighted several group-based therapies that clients found particularly helpful this year. These include the infant massage and self-regulation groups, of which the latter was co-hosted with BHRS Alcohol and Other Drug (AOD) services staff. The objectives of

the 5-week self-regulation class were to teach children about the arousal states that a body goes through when feeling too high, too low, and just right and to practice using evidence-based strategies for returning to a "just right" arousal state. Components of the curriculum included psychoeducation for both child and parent, movement activities, craft activities, creative learning strategies, games, and self-reflection. The positive impact of the 5-week self-regulation class on several Prenatal to Three clients is described in detail below.

Client Story #1: Two of the three children participating in the self-regulation group showed significant improvements over the course of the 5-week class, which clinicians attributed in part to consistent attendance by their parents and each family's commitment to use of arousal state language outside of class. Specifically, both children demonstrated progress in their comprehension and use of self-regulation vocabulary, identification of arousal levels in others and themselves, and receptiveness to actively participating in group-based activities. One of these clients initially experienced difficulty engaging with his peers in appropriate ways during group-based activities. However, by the end of the class, this client was actively practicing strategies in a group setting and appropriately engaging in games with peers and adults. He also verbally expressed how much he would miss being in the group.

Trauma-informed care, especially the opportunities afforded through the Neurosequential Model of Therapeutics (NMT) program's contracts with community-based organizations, also represents a major success. NMT flex funds have allowed Prenatal to Three Initiative clients to participate in swimming classes, martial arts, equine therapy, and other therapeutic activities that involve movement and can thus help clients with a history of trauma regulate their emotions. Relatedly, several therapists who recently obtained a trauma-informed Cognitive Behavioral Therapy (CBT) license have experienced success using narratives with clients and practicing Eye Movement Desensitization and Reprocessing (EMDR) therapy.

Finally, an occupational therapist hired this year has implemented multiple sensory interventions that enhanced clients' self-awareness and resiliency. This clinician uses the Integrated Listening System (ILS) Focus Listening Program to rewire the brain in children suffering from frequent emotional dysregulation, high anxiety, inattention, and auditory hypersensitivity, among other conditions. Clients wear a special headset that delivers auditory and vibrational sensations while completing a movement task for the first 15 minutes and a simple cognitive task or quiet activity for the remaining 15 minutes. One client in particular benefitted immensely from completing a 60-hour "Sensory Motor" listening protocol during weekly clinic and at-home sessions; his story is detailed below.

Client Story #2: The child initially presented with sensory sensitivity, hyperactivity, and difficulty maintaining focus and following verbal instructions. At the beginning of the Sensory Motor protocol, this client was unable to keep his headphones on for more than 3 minutes at a time, requiring breaks and redirection to continue with the session. However, the client's functioning steadily improved as he continued working with the protocol in his weekly session and at home. After completing all protocol hours, this client was able to actively engage in the entirety of the

movement-based and quiet activities, follow all instructions without requiring redirection to task, and appropriately transition to leave the sessions with his mother without incident.

Challenges

The most significant challenges experienced by Prenatal to Three Initiative leadership this year have been difficulties retaining current staff and hiring qualified candidates to fill open positions. Higher caseloads have increased the burden on remaining staff members, leading to burnout and several leaves of absence, further straining staff. For example, in the months leading up the end of the FY 2021-22, as many as four of the nine clinician positions for the Partners for Safe and Health Children program were vacant at a single point in time. Program supervisors noted that it is difficult enough to handle existing volume when all budgeted positions are filled; ideally, future year budgets would include funding for additional mental health staff. Furthermore, existing clinicians have indicated that they could benefit from additional administrative support. One family partner employee currently provides case management services on behalf of overburdened Prenatal to Three Initiative mental health clinicians, but funding for additional administration positions is needed to improve the comprehensiveness and timeliness of social services screening and referrals.

Greater administrative support is important because unmet social needs can hinder clients' mental health treatment. Program supervisors noted that many families they serve still struggle to fulfill their basic needs—adequate food, housing, childcare, etc.—without assistance. In particular, leadership would like to improve coordination with county staff who manage public housing resources so that homeless clients can obtain a safe place to live more quickly. In addition, leadership would like to develop stronger relationships with local providers that offer early intervention services, such as the Golden Gate Regional Center (GGRC) and Stanford University's Development Clinic, and connect clients interested in pursuing employment opportunities with affordable childcare resources.

Another challenge closely related to staff retention is the recent increase in more complex client cases. For example, program staff have observed an increase in the prevalence of alcohol and other drug use by pregnant clients. Relatedly, they have encountered a greater number of medically fragile babies, including those who have tested positive for methamphetamines and other drugs. In addition, staff have observed an increase in cases of severe domestic violence witnessed by young children, incarceration of caregivers, and placements of children in foster homes. It is both more time-consuming and distressing for clinicians to support clients who are experiencing more frequent and acute mental health crises. However, program leaders are committed to helping staff cope with stressful cases. For example, supervisors encourage staff to share and process the difficult interactions they have had with clients recently during team meetings and to frequently engage in self-care practices. Leadership has also organized retreats and team lunches that provide an opportunity for staff to recharge.

In addition, managing referrals to the Prenatal to Three program has become quite cumbersome. While staff have created a standard referral form in an attempt to simplify the process, many providers continue to refer patients without submitting the form or providing

adequate mental health detail. Staff have requested that providers submit referral forms to a shared mailbox, but many simply relay information via fax, a phone call, or an email sent directly to a program supervisor. Furthermore, providers that use eClinicalWorks often choose to submit referrals through this electronic health records (EHR) system, further disrupting the workflow for servicing the Prenatal to Three program's high-risk population. Because the county uses a separate EHR system, AVATAR, with different standard reporting fields, staff end up spending extra time following up with providers to obtain missing information and manually entering data into AVATAR. Widespread noncompliance with the standard referral process, coupled with high referral volume, makes it incredibly time-consuming for the program supervisor to review and determine if each referral meets eligibility criteria.

Lastly, Prenatal to Three program staff have had fewer resources at their disposal ever since the Family Health Services (FHS) division began implementing an evidence-based program for low-to-moderate risk populations. FHS staff are no longer permitted to provide any case management support to clients with SMI, leaving Prenatal to Three program staff solely responsible for handling the growing number of high-risk clients. Providers have also struggled to adjust to the shift, with some continuing to refer low-to-moderate risk clients to the Prenatal to Three program by mistake.

Finally, program leaders mentioned that several of the program clinicians they supervise have expressed feeling uncomfortable discussing substance use problems with clients due to their limited knowledge of treatment options. Program leaders plan to improve staff's capacity to support clients with substance use disorders by collaborating more frequently with AOD staff. For example, the program manager plans to ask Mary Fullerton and Clara Boyden of AOD to lead a training for Prenatal to Three Initiative staff that covers screening and referral best practices as well as a summary of available treatment options. Greater knowledge of local substance use treatment providers would help facilitate timely referrals for clients affected by these issues. Another potential solution would be to encourage Prenatal to Three Initiative staff to independently pursue continuing education classes on substance use disorder treatments. One staff member was recently appointed the Prenatal to Three Initiative's AOD specialist after completing several AOD webinars; supervisors may consider promoting similar opportunities for other staff. Finally, program leadership proposed renewing efforts to recruit local parents with experience undergoing treatment for a substance use disorder to serve as a peer navigator for clients who are actively struggling with an addiction. Clients who report difficulty curbing substance use are often more open to speaking with peers who have relevant lived experienced than with mental health clinicians.

Demographics

The table below summarizes the demographic information for the 750 clients who were admitted and actively a part of the of the Prenatal to Three Initiative during FY 2021-22.

Age category	Percentage	Race	Percentage
0–15	23.5%	Other	58.4%
16–25	21.2%	White/Caucasian	6.9%
26–59	55.3%	Multiple	3.5%
60 +	0.0%	Black	2.0%
Primary language	**Percentage**	Asian Indian	0.9%
Spanish	47.5%	Filipino	0.7%
English	45.9%	Samoan	0.5%
Portuguese	1.9%	Other Asian	0.4%
Arabic	0.8%	Hispanic	0.3%
Russian	0.4%	Tongan	0.3%
Tagalog	0.3%	American Native	0.3%
Other Non-English	0.3%	Other Pacific Islander	0.3%
French	0.1%	Chinese	0.1%
Farsi	0.1%	Unknown / Not Reported	25.5%
Unknown / Not Reported	2.8%	**Ethnicity**	**Percentage**
Sexual orientation	**Percentage**	Hispanic or Latino	63.7%
Straight or heterosexual	20.7%	Not Hispanic or Latino	16.7%
Bisexual	1.2%	Unknown / Not Reported	19.6%
Decline to state	0.8%	**Sex assigned at birth**	**Percentage**
Another	0.3%	Female	85.7%
Lesbian or gay	0.1%	Male	14.1%
Unknown / Not Reported	76.9%	Unknown / Not Reported	0.1%

PUENTE CLINIC

Puente Clinic was created in 2007 under BHRS to accommodate the sudden increase of psychiatric service need due to the closure of Agnews Developmental Center and relocation of many intellectually disabled adults to San Mateo County. The word “Puente” means “Bridge” in Spanish, and it implies helping clients bridge what could be a life of dependence and isolation to a life of independence and integration with the whole community. Clients with intellectual disability have higher comorbid psychiatric disorders, face more stressors and traumatic exposure in life, and experience more stigmatization and discrimination. But limits in

communication/cognitive ability and aberrant brain development/function make it challenging for behavioral health providers to assess, diagnose, and treat these clients.

Clinical staff at the Puente Clinic are trained and experienced in working with adult clients with both intellectual disability and psychiatric conditions. In carrying out this unique function, Puente Clinic collaborates closely with the San Mateo County Branch of the Golden Gate Region Center (GGRC), which coordinates essential benefits (daily living, housing, etc.) for County residents with intellectual disabilities. Puente Clinic serves as the lead clinical team in BHRS to receive psychiatric service referrals from GGRC. The team provides assessment, psychotherapy, medication management and coordinates case management with GGRC social worker/case managers. Currently, Puente Clinic has one Full-Time Marriage and Family Therapist, two Half-Time Psychiatrists, and one Half-Time Nurse Practitioner. A typical client referred to Puente Clinic is someone having mild to severe intellectual disability, often with significant limits in communication ability, with one or more of the following conditions:

- Client is returning to the community from a developmental center or a locked or delayed egress.
- Client is at risk for a higher level of care.
- Client requires in-home services as clinically determined.
- Client has had multiple psychiatric emergency services contact.
- Client has complex diagnostic issues or poly-pharmacy.

Program Impact

Puente Clinic – Dual Diagnosis	FY 2021-22
Total clients served*	272
Total cost per client	$1,336

One of the outcome data Puente Clinic continues to track is the utilization of Psychiatric Emergency Services (PES) at the San Mateo Medical Center, which is the triage center for acute psychiatric emergency in the county. One Puente Clinic's tasks is to ease the transition of intellectually disabled clients with aggressions that endanger self or others from a locked or highly structured institutional setting to the much less restricted community environment. To achieve this, individual psychotherapy, medication management, and close collaboration with GGRC and its support teams are needed to reduce disruptive and aggressive behaviors and to maintain stability in high-risk clients.

In FY 2021-22, 8 unique Puente clients had PES episodes, with a combined total of 19 episodes. This was 3% of the total caseload, and 2% more compared to last fiscal year. Given the context of the pandemic along with departures of long-term staff this fiscal year, the overall low percentage numbers indicate that Puente Clinic has been able to continue to provide effective outpatient-level services. Despite disruptions to care with staffing transitions and the changed structure of appointments, the team's outpatient level services have been able to limit the use

of higher-level interventions, such as PES, and to maintain the stability of most clients in its caseload.

Puente Clinic and GGRC have jointly created a “Referral Form” to facilitate the recording and transmitting comprehensive referral information. This special arrangement allows dedicated attention to clients diagnosed with intellectual disability and mental illness. This client population often gets ignored and underserved due to limited self-advocacy and self-refer. A GGRC social worker sends this “Referral Form” to the Puente Clinic to initiate a screening process to identify Medi-Cal clients who meet medical necessity criteria. Over time, the Puente Clinic and GGRC continue to improve this form to make the referral process streamlined. Once the Puente Clinic receives this form, the case is quickly reviewed for the appropriate level of service and treatment provider. Clients with limited communication ability tend to stay with the Puente Clinic providers, but other BHRS regional clinics could also serve clients with appropriate communication skills. When a client’s symptoms are in the Mild-to-Moderate range, referral to Private Provider Network will be made.

The establishment of Puente Clinic was meant to create a special workforce with expertise in treating clients with both intellectual disability and severe mental illness in a timely fashion. By removing barriers to care, this clinical team helps to reduce stigmatization and discrimination that clients with intellectual disabilities often experience. Co-location of Puente Clinic and several other BHRS clinical teams helps normalize a sense of being welcome when these clients come to the clinic location, as they are treated with the same attention and respect as others. In addition, the Puente Clinic providers regularly offer training to other BHRS teams to inform skills and knowledge that help to work with clients of this population. Puente Clinic also actively participates in the training of Licensed Marriage and Family Therapy (LMFT) and Licensed Clinical Social Worker (LCSW) interns and nurse practitioners on best practices in working with intellectually disabled clients to reduce the resistance of mental health providers in serving this client population.

Over the past few years, the census of the Puente Clinic continued to increase annually. But in addition to enhancing referral pathways to help with access to behavioral health treatment, the Puente Clinic providers also facilitate connecting clients with primary care providers and other specialty services covered by Medi-Cal benefits. In addition, there is a communication channel among the leadership of Puente Clinic, GGRC, and the Health Plan of San Mateo (HPSM) to resolve conflicts that cause barriers to care. Minimally every quarter, these three entities meet to discuss improving public health services to the intellectually disabled population.

Puente Clinic clients come from diverse social backgrounds. Each provider has received numerous Cultural Humility training and applies the learning to clinical care and service coordination involving clients, families, caretakers, and parallel professionals. The Puente Clinic providers constantly help clients who can’t advocate for themselves to pursue ancillary services that cover needed social benefits. In clinical sessions, interpretation services are provided as needed through phone or in-person arrangements, including sign-language interpretation.

The Puente Clinic providers infuse hopefulness in clients, families, and caretakers to help each client to achieve the highest level of functioning one could get. The successful outpatient treatment model that Puente Clinic provides helps the client live in the least restrictive setting in the community. Many Clinic clients came out of an institutional setting, such as a Development Center, were clients often experienced multiple types of traumas of verbal and physical nature. Still, Puente Clinic helps these clients process their trauma experiences and recover over time. When a client is cognitively capable, supportive psychotherapeutic treatment is always provided to enhance personal agency in achieving life goals. The Clinic works closely with GGRC and the Department of Rehabilitation to find the best educational and vocational opportunities for clients. It works with local community groups to promote social connections and increase educational resources for clients.

Successes

Client Story #1: AS - 23 year old AA male, non-verbal non conserved, GGRC client. Diagnoses include fetal alcohol syndrome, epilepsy, moderate intellectual disability, attention deficit and hyperactivity disorder, and impulse control disorder. Client was opened to Puente Clinic in March 2019. Client relocated to San Mateo County after spending three years in a locked facility, due to severe aggressive outbursts in the community, causing grave bodily harm towards professional caregivers. Client now receives 24-hour round the clock care, provided by supported living services vendor. Client was matched with ethnically, culturally appropriate caregivers. Client's maladaptive behaviors include physical aggression, property destruction and elopement. Initially he was having approximately one behavior per month resulting in approximately three 911 calls or psychiatric emergency room visits per year. His behaviors intensified due to school closure from the pandemic. Since his school reopened, behaviors have decreased. He has had no aggressive outbursts over this last year. His medication originally prescribed at the locked facility caused weight gain of 100lbs. The client has been successfully transitioned to medication with less metabolic side effects.

Client Story #2: EB - 49 year old female, non-verbal non conserved, GGRC client. Diagnoses include moderate intellectual disability, intermittent explosive disorder and seizure disorder. Client has been followed by Puente clinic since April 2016 for medication management. The reason for the referral was aggressive outbursts at her group home and out in the community. At the time client was living in a non-behavioral group home with staff who were not trained in behavioral redirection. Client moved to a behavioral group home in October 2021. Medication intervention had at most a modest positive effect in decreasing aggressive behaviors. Change in placement has had the greatest impact. Aggressive behaviors are now quiescent. Client appears to be calm and content.

Challenges

Client Story #1: MB - 53 year old non conserved GGRC client. Fully verbal woman with intermittent explosive d/o, cerebral palsy, blind, and chronic, severe maladaptive bx including social disruption, false accusations including false 911 calls when she does not get her way. Pt has traits of narcissism and Borderline Personality Disorder (BPD). Residing at group home for close to 20 years. No behavioral boundaries were set by family nor presently by group home. Client has been followed by Puente clinic for medication management since September 2009. Medication intervention has had limited benefit in decreasing behaviors, which have escalated over the last 6 months due to her elderly mother being ill. Client is at risk of losing placement because of her behaviors. Staff are not trained in behavioral redirection and the contracted behavioral psychologist is minimally involved. The group home has declined crisis intervention and behavioral support. Client refuses to attend psychiatric appointment and medication adherence is sporadic. Client would benefit from probate conservatorship as she has very limited medical decision making capacity.

Client Story #2: KR - 41 year old non conserved male GGRC client. Fully verbal with diagnosis including bipolar disorder, anxiety disorder and mild intellectual disability. Client also meets criteria for antisocial personality disorder and pedophilia. He has 24-hour round the clock care provided by supported living services. Has been followed by Puente clinic since Dec 2015, after being released from jail for arson. He is prone to rapid mood swings and anger outbursts. He has multiple medical comorbidities secondary to morbid obesity including congestive heart failure, recurrent, infected sores in lower extremities. He is a high utilizer of emergency medical services and non-compliant with following up with outpatient care, both mental health and primary care. These challenges have been raised by his outpatient care team to his social worker at Golden Gate Regional Center. Outpatient care team has been informed that GGRC cannot intervene as client is not conserved and has medical decision making capacity.

Demographics

Last fiscal year, 5.82% of clients had unknown/not recorded ethnicity, and the goal was to reduce this to 0% by revising the referral form to include race and ethnicity. As there were multiple staff departures the second half of the fiscal year, client load was maintained, and no referrals were received to be able to improve rates of unknown/not recorded ethnicity. The unknown/not recorded race maintained at 0%. As BHRS continues to recruit for staff, the goal for next year is to reduce unknown/not recorded ethnicity to 0% as new referrals resume. The following tables include any client who had an episode open for at least one day during FY 2021-22. Clients were counted in multiple race groups if indicated belonging to multiple races.

	FY 2021-22
Age	
20-29	13.19%

30-39	17.22%
40-49	21.09%
50-59	20.51%
60-69	23.08%
70-79	6.96%
80-89	0.73%
Sex at Birth	
Male	58.82%
Female	41.54%
Race/Ethnicity	
White or Caucasian	51.47%
Black or African American	12.13%
Other Race	11.40%
Chinese	6.62%
Unknown / Not Reported	6.25%
Filipino	4.78%
Mixed Race	1.84%
Korean	1.84%
American Indian or Alaska Native	1.10%
Other Asian	0.74%
Vietnamese	0.37%
Other Asian or Pacific Islander	0.37%
Japanese	0.37%
Hispanic	0.37%

TRAUMA-INFORMED INTERVENTIONS

The Neurosequential Model of Therapeutics (NMT) program within the BHRS Adult System of Care was created to improve the well-being of clients who have experienced severe trauma. NMT-certified providers rely on assessments of clients' functional capacities in four domains—sensory integration, self-regulation, relational, and cognitive—to inform the selection of individualized therapeutic interventions. The NMT program manager provides training and ongoing technical assistance to county clinicians tasked with delivering specialty mental health services to one or more of the following groups:

- General adult consumers (ages 26+)
- Transition Age Youth (TAY) consumers (ages 16–25)
- Criminal justice-involved consumers re-entering the community following incarceration

Twice annually, the NMT program offers a 2-month training course on the Six Core Strengths, a framework devised by neuroscientist Bruce Perry to explain how trauma disrupts children's development. This 16-hour class is a prerequisite for a yearlong training course teaching

clinicians how to conduct NMT assessments for adults. Eight county clinicians who work with adult clients currently hold an NMT certification, while another two clinicians are in the process, which requires a total investment of about 120 training and study hours.

NMT-trained clinicians perform two primary activities: (1) conducting initial and follow-up NMT assessments and (2) creating and refining customized treatment recommendations. As part of the initial assessment, clinicians collect information about a client's adverse experiences as well as their relational history, noting any evidence of past difficulty building and maintaining healthy relationships, and document observations of the client's current presentation and relational health. Entering all of this data into the NMT portal generates a metric known as a brain map that shows functioning for the client side-by-side with the brain map for a healthy adult of the same chronological age. Clinicians review the brain map to identify relative strengths and vulnerabilities across the four functional domains.

Based on this analysis, clinicians recommend specific therapeutic interventions that promote the development of functional capacities within the domain(s) in which the client showed the largest deficits. Clients are commonly referred to one or more MHSA-funded contracted service providers to participate in guided therapeutic activities, including trauma-informed yoga, equine therapy, swimming, martial arts, and intensive speech therapy. In addition, the NMT program provides flex funding to cover the cost of gym memberships—allowing clients to engage in self-directed exercise—and funds clients' self-care tools, including weighted blankets, sound machines, and gliders. Clients' use of these self-care tools and engagement in group-based therapeutic activities complement traditional mental health care services such as talk-based therapy and psychiatric medications. Six months to a year after generating the most recent brain map, clinicians administer follow-up assessments to facilitate analyses of changes.

Program Impact

Trauma-Informed Interventions (NMT)	FY 2021-22
Total clients served*	69
Total cost per client	$3,058

The NMT program fulfills MHSA objectives primarily through its commitment to **implementing recovery principles.** First and foremost, NMT is a trauma-informed treatment approach. Clinicians are trained to match interventions with the developmental readiness of the client and to foster an environment that feels safe to the client. Involvement in the NMT program can also empower clients to become more actively involved in management of their care plan. For example, clinicians have shared educational slides with several clients who expressed an interest in learning more about how trauma impacted their brain development. When one of these clients subsequently planned to move to another county, she requested a copy of the presentation slides to share with her next therapist. This client planned to use the slides to better explain how some symptoms stem from the trauma she experienced and spark a discussion of the approaches that work best for her as a survivor of trauma.

In addition, program staff promote care integration by sharing information with other providers about the ways in which they can reduce the distress commonly experienced by clients in other health care settings. In training, county mental health clinicians are encouraged to advocate for their clients in a way that empowers them and makes them feel understood. Finally, the NMT model gives practitioners flexibility to address clients' needs in a way that is sensitive to their cultural backgrounds. Clinicians work collaboratively with clients to identify appropriate therapeutic activities that best align with their cultural practices, faith, and family values.

Moreover, the NMT program helps **reduce the stigma and discrimination** experienced by clients with severe mental illness by educating healthcare providers and staff within the broader public assistance system. Finding certain diagnoses in a client's medical record (e.g., a personality disorder) can automatically cause clinicians to assume that the client will be difficult because they are likely to have boundary issues. However, the NMT model promotes greater compassion for neurodiversity by helping clinicians better understand past experiences that have caused the client to present in a maladaptive way in order to get their needs met. Clinicians also use NMT findings to counter discriminatory beliefs held by probation staff, judges, child protective services staff, and other medical staff. For example, clinicians can present clients' sensory profile data to explain why some clients present as difficult within a particular setting (e.g., residential treatment facilities) and to recommend accommodations that clients may need to function optimally.

Because clients referred to the NMT program are already receiving mental health services through a county clinic or contracted service provider such as Caminar or Edgewood, the NMT program does not directly address the timeliness of or disparities in access to initial mental health services. However, the NMT program **reduces disparities in access to high-quality, trauma-informed care** by empowering county clinicians to connect low-income clients with additional services and resources that clients could not otherwise afford but which are regularly utilized by those with greater financial resources, including equine therapy, intensive speech services, and weighted blankets.

Finally, the NMT program may have indirectly **increased the number of individuals receiving developmentally appropriate mental health services** through technical assistance provided to county clinicians. Due to substantial capacity constraints within the county's behavioral health treatment system, the NMT program manager often offers to conduct an initial NMT assessment on behalf of county clinicians with limited capacity. She also coaches county clinicians on ways they can conduct NMT assessments more efficiently.

Successes

Program leadership attributed broad improvements in adult clients' relational skills to the expertise and compassion of SMC's NMT-certified therapists. While adult NMT clients do not generally show gains in their cognitive, sensory integration, and self-regulation abilities as rapidly as youth NMT clients, there is clear evidence of improved relational functioning after a year of therapy for many adult NMT clients. NMT training encourages county mental health

providers to look beyond a diagnosis and set of symptoms when treating clients with a history of trauma, exploring how key events shaped them into the person they are today and celebrating the strengths they drew upon to survive tough situations.

In addition, NMT clients from the pain clinic have benefited immensely from their participation in group-based or private yoga classes. Pain clinic clients' receptiveness to engaging in trauma-informed yoga is especially important because many have relied on medications for a long time and have difficulty accepting support outside of medication. Another NMT client, whose story is described below, underwent a remarkable transformation after participating in a yoga class.

Client Story: A client diagnosed with depression recently agreed to participate in private yoga sessions and has shown drastic improvements over the last year. Before starting yoga, this client had been in therapy for 4 years without showing much progress. The client struggled with intense negative feelings caused by a 20-year estrangement from her family as well as an unhealthy, highly dependent relationship with an ex-partner who did not treat her well. However, since committing to regular yoga sessions with her instructor, this client's therapist has noticed a marked increase in her self-esteem and confidence. During the time that she has practiced yoga, the client has reconnected with her estranged family members and spent quality time with them. She also mustered the courage to confront her ex-partner and terminate her dependent relationship with him.

Challenges

The most significant challenge faced by NMT program leadership over the past year is retaining enough county staff with active NMT certifications. Several factors have contributed to a recent decline in the number of NMT-certified clinicians, including high employee turnover, a statewide shortage of qualified mental health practitioners, and more stringent enforcement of annual licensing requirements by the NMT governing body. During the first 2 years of the COVID-19 pandemic, the NMT governing body relaxed the requirement that certified clinicians complete a minimum of five maps annually to maintain their certification. However, over the past year, the NMT governing body has started requiring clinicians whose certification lapsed to complete mandatory training before agreeing to reopen their portal account, which is the interface used to create brain maps. Unfortunately, due to high employee turnover and slow rehiring, many NMT-certified clinicians have found it much more difficult to fulfill the annual five-map requirement.

While the ideal long-term solution to these capacity constraints would be for SMC leadership to fund new mental health positions and streamline their hiring practices, the NMT program manager also plans to adjust her approach to training next year in recognition of the importance of maintaining existing NMT certifications. Instead of offering a new NMT certification training cohort next year, the program manager plans to lead a technical assistance program to support current licensed NMT practitioners. They will meet multiple times throughout the year, but only six times in person, and the emphasis will be on completing maps most efficiently. The first hour of the in-person training sessions will be dedicated to completing an assessment for one of their clients. The program manager hopes that this structure—

essentially making the in-person meetings a billable session—will incentivize greater participation because they will not significantly detract from clinicians' productivity rates.

A related challenge is setting up a reliable mechanism for reminding NMT-certified clinicians to complete timely updated maps for all clients who undergo an initial assessment. Ideally, clinicians should create a new map every 6 months to a year in order to assess changes in each client's functioning, which would then inform decisions to continue or modify specific therapeutic interventions. Unfortunately, NMT-certified clinicians have found it increasingly difficult to set aside time for map updates this year as their caseloads have grown. One potential mitigation strategy involves giving NMT program staff more responsibility over tracking the initial map creation dates and sending reminders to clinicians when it is time to do an update map. Funding for another full-time employee would make this solution more feasible. The program manager, who also carries a caseload for BHRS's Prenatal to Three Initiative, reported feeling overwhelmed at times by the volume of existing administrative tasks, including contracts management, tracking flex funds, and processing adjunct services referrals. Delegating some of this work to another staff member would enable the program manager to more closely monitor and support clinicians' creation of update maps.

Finally, the NMT program manager noted that a lower proportion of adult clients engage in supplementary therapeutic activities recommended by their NMT-trained therapist relative to child clients. While the exact reasons for this discrepancy are unknown, adult clients most commonly reported difficulty arranging for transportation as the main barrier. For example, the remoteness of the equine therapy facility, which is not easily accessible using existing public transportation routes, makes it much harder for clients to secure transportation to and from the ranch. Though Medi-Cal will reimburse clients for the cost of a Lyft or Uber ride to a therapeutic service, drivers often arrive late or cancel the ride request after struggling to locate the equine facility. Because current evidence suggests that it is easier for adult clients to engage with yoga, the NMT program manager plans to decrease the budget for equine therapy and increase funding for yoga in future fiscal years.

Demographics

	FY 21-22		FY 21-22
Age category	**Percentage**	**Ethnicity**	**Percentage**
0–15	0.0%	Hispanic or Latino	52.2%
16–25	49.3%	Not Hispanic or Latino	34.8%
26–59	46.4%	Unknown / Not Reported	13.0%
60+	4.3%		
Primary language	**Percentage**	**Sex assigned at birth**	**Percentage**
English	82.6%	Female	76.8%
Spanish	17.4%	Male	23.2%
Race	**Percentage**	**Sexual orientation**	**Percentage**

Other	43.5%	Straight or heterosexual	33.3
White/Caucasian	29.0%	Bisexual	8.7
Hawaiian Native	2.9%	Lesbian or gay	7.2
Filipino	1.4%	Decline to state	4.3
American Native	1.4%	Another	1.4
Multiple	1.4%	Asexual	1.4
Unknown / Not Reported	20.3%	Unknown / Not Reported	43.5

EVIDENCED-BASED PRACTICE (EBP)

Evidence-Based Practice Clinicians	FY 21-22
Total clients served	438
Total cost per client	$3,471

System transformation is supported through an ongoing series of training that increase the utilization of evidence-based treatment practices that better engage consumers and family members as partners in treatment and contribute to improved consumer quality of life. MHSA funding supports staffing specialized in providing evidence-based services for youth and adult clients throughout the system.

SCHOOL-BASED MENTAL HEALTH

School-Based Mental Health (SBMH) program identifies students suffering from serious mental illness (SMI) and connects them with appropriate behavioral health services that enable them to continue receiving classroom instruction. In FY 2021-22, SBMH staff provided clinical assessment; talk, art, and play therapy; and case management services to 345 students across 23 school districts. Roughly 80% of participating students are eligible for Medi-Cal. Staff serve the following groups:

- Newly referred students expected to meet medical necessity criteria for an individualized education program (IEP) on the basis of SMI screening results
- Current special education students with ongoing SMI needs identified in a prior school year

Primary program activities include reviewing SMI screening results; conducting the initial assessment required for an IEP package submission; presenting assessment findings at an IEP meeting; developing a treatment plan in collaboration with each student, their caregivers, and their instructors; delivering behavioral health services outlined in each IEP; contributing to annual IEP progress reports; assigning family partners to support caregivers; and conducting ongoing consultations with special education instructors, school counselors or psychologists, caregivers, and others who comprise each student's support network.

A manager and four supervisors oversee SBMH program operations, assigning one of 23 BHRS mental health clinicians to newly enrolled students and serving as liaisons between each school district's staff and BHRS-affiliated service providers. Before a student begins receiving school-based behavioral health supports, a SBMH supervisor will first review an SMI screening form submitted by school staff. For referrals deemed appropriate, an SBMH clinician will then conduct an assessment with the student to determine whether they meet the diagnostic criteria for an SMI and to identify behavioral health services that may support optimal functioning in school. Finally, the SBMH clinician will present a subset of the assessment results at an IEP meeting. If the IEP team agrees with the clinician's recommendation for behavioral health services, the clinician will work with the student's support network to finalize the treatment plan. While the services covered by each student's IEP vary, SBMH clinicians can provide individual and group therapy during school hours as well as family counseling outside of school. Medi-Cal students can also meet with county psychiatrists outside of school to receive prescription medications for their SMI.

SBMH clinicians may also recommend that school staff refer students with maladaptive behaviors to either the Fred Finch Youth Center or Edgewood Center for wraparound services. The wraparound model is designed to prevent higher level placements, such as residential placement, incarceration, or hospitalization, by helping students develop self-calming skills and embrace other strategies for curbing inappropriate behaviors. In those cases, SBMH clinicians and educators will present at an Identification, Placement, and Review Committee meeting to request approval for the referral. In addition to delivering services required by the school district under the terms of each IEP, SBMH clinicians facilitate student referrals to off-site providers of other behavioral health services. Many students are encouraged to participate in movement-based therapeutic activities, such as yoga and equine therapy sessions led by Neuro-Sequential Model of Therapeutics program partners. Furthermore, SBMH clinicians refer students who could benefit from and meet eligibility criteria for Therapeutic Behavioral Services (TBS) to the Fred Finch Youth Center.

Program Impact

School-Based Mental Health	FY 2021-22
Total clients served*	345
Total cost per client	$1,449

The SBMH program has sought to increase the total number of students with SMI receiving public health services while simultaneously reducing disparities in access to care by shifting staff to school districts with a greater number of traditionally underserved Medi-Cal-eligible students and a higher unmet need with a greater number of students from low-income families. Coordinating behavioral health service visits with students in school reduces barriers

to care for students whose parents work multiple jobs or rely solely on public transportation, as these factors can make it difficult to arrange for recurring mental health clinic visits.

The speed with which materials for the IEP package are developed by individual school staff is the greatest driver of **timely access to care**. SBMH program staff have taken steps to expedite this process by creating a standard referral screening form and a secure mailbox for receiving completed forms. After receiving new referrals, program staff strive to vet them quickly to determine eligibility and inform school staff of any additional documentation required to proceed with an assessment and presentation at an IEP meeting. Staff also try to articulate clear definitions for conditions that qualify as SMI to reduce the number of referrals they receive for students with mild or moderate mental health conditions.

The SBMH program helps **reduce the prevalence and severity of stigma** felt by special education students and their caregivers, by doing the following:

- Providing students with the support they need to remain in their current classrooms; this promotes feelings of inclusion that would not be would not be possible if behavioral disruptions persisted and required a transfer to a more secluded environment
- Providing parents with psychoeducation to help them understand and navigate two disparate systems—the special education and mental health systems—without feeling stigmatized by caring for youth with "special needs"

In addition, county clinicians strive to **mitigate discriminatory attitudes** toward students with SMI by arranging to speak with special education instructors who have unrealistic expectations for students' behavior. Program staff collect and share background information on individual students and their families, including key challenges and limitations, that inform ways in which educators might work more effectively with those students.

Program staff demonstrate a commitment to **implementing recovery principles**. SBMH program clinicians try to promote a high degree of student and family involvement in the development of treatment plan goals to make it more of a collaborative process, *empowering them to take an active role in their own care.* Patient self-activation is also accomplished through referrals to TBS clinicians, who can help students learn to verbalize their needs and advocate for themselves. Moreover, staff provide *culturally sensitive care* by matching families to culturally appropriate services. For example, family partners can advocate on behalf of families to access interpreter or translation services in the school setting. These family partners often attend IEP meetings and provide a bridge to ensure that monolingual Spanish-speaking parents or other non-English-speaking parents understand the school culture, the IEP process, and key points conveyed in meetings. Program staff also coordinate "family café" events for caregivers and family partners that function as support groups, thereby *facilitating the involvement of community members*. Finally, program staff *promote trauma-informed care* by funding students' participation in movement-based therapeutic activities, such as yoga and equine therapy, which evidence suggests can improve self-regulation in clients.

Successes:

The weekly therapy sessions that are a part of many students' IEP plans have been very successful. The consistency of these behavioral health services helps foster trust, reducing students' anxiety as they learn that they can rely on their therapist for support through difficult times. The story of one student, described in detail below, is a testament to the positive impact of county mental health clinicians on students' well-being.

Client Story #1: A 17-year-old client began receiving School-Based Mental Health Program services in middle school due to severe depression over his mother's cancer diagnosis. Because this student was experiencing extreme grief as he watched his mother die, he was often very irritable with school staff, peers, and his aunt. He also expressed a lot of suicidal thoughts. However, after several years of meeting with his therapist, this student began to trust the treatment process. He now regularly meets with a psychiatrist, and as his depressive symptoms lessened, he began to flourish in multiple domains where he had once struggled to function. This student currently earns good grades, plays for his school's football team, and is considering applying to colleges before graduating next year.

A second client success story, described in detail below, demonstrates how clinicians' compassion, stability, and persistence can diffuse tension that can arise between caregivers and school staff. Mediating these conflicts is important because students are more likely to make progress when parents, educators, and mental health staff all embrace and take an active role in supporting their treatment plan. More broadly, the greater availability of teletherapy during the COVID-19 pandemic has benefitted students suffering from SMI by making it easier for parents and clinicians to regularly connect and discuss recent progress or setbacks. As a result, program staff have observed many caregivers becoming more engaged in their child's treatment plan.

Client Story #2: School staff had warned a program clinician that a newly enrolled student's mother would be unlikely to cooperate with her child's treatment plan. This mother had previously been recorded on social media doing something inappropriate with her child, and as a result, school and local community members formed a negative impression of her. However, over the past 6 months, this student's therapist has made a concerted effort to build a positive working relationship with the mother. She is now willing to accept support from the therapist, who is also helping to bridge the gap between school staff and the mother. Because of the therapist's compassionate and tactful mediation, school district staff are now amenable to trying different approaches that the mother finds acceptable. Likewise, the mother has demonstrated a newfound willingness to engage in regular conversations with school staff and more actively support her son's academic progress.

Finally, referrals to the Edgewood Center for wraparound, such as family therapy, behavioral coaching, and family partner consultations, have been highly successful. In many cases, services rendered through Edgewood have allowed families to avoid out-of-home placements.

Challenges

High staff turnover and difficulty hiring replacements represent the greatest challenge faced by program leadership over the past year. Departures force remaining staff to take on even greater caseloads, increasing their stress levels and reducing the quality of care provided. While program leaders are working with BHRS Talent and Acquisition staff to conduct targeted recruitment of mental health clinicians, especially those who are Spanish speaking, there is currently a statewide shortage of mental health clinicians. In addition, county government rules about the types and level of benefits that can be offered to employees make it more difficult to attract qualified candidates. Private employers, such as Kaiser Permanente, commonly offer more attractive telework positions and high signing bonuses.

One possible solution would be for the county manager and board of supervisors to approve modifications to the types of benefits available to county employees with the goal of making requisitions more enticing to potential hires. Because this may not be feasible, program leaders are also working on identifying ways to reduce the burden of treatment documentation requirements to lighten the load on existing clinicians as hiring continues. While the California Advancing and Innovating Medi-Cal (CalAIM) is intended to streamline documentation requirements, implementation has been fairly uncoordinated over the past year. Technically, all counties should now be operating under the new guidelines, but rollout of the universal screening tool was recently delayed until January 2023. Program leadership recommended asking the state to provide more clarity around the planned transition to the CalAIM system. They mentioned that phased implementation has made it more difficult for program staff to develop a holistic understanding of the new system. In addition, there is substantial variation in the comprehensiveness and quality of notes logged by school staff, which can make it difficult for SBMH clinicians to meaningfully evaluate some students' progress against IEP goals in annual reports.

A second challenge relates to district staff making unilateral decisions without first consulting with SBMH program staff. For example, some school districts have recently decided to place students under the care of contracted mental health providers from an outside agency or new internal hires. This is disruptive to both clinicians and students, especially in cases in which very little advance notice is provided. In some extreme cases, existing county clinicians have been told to never contact the student again despite having established a strong relationship with the client over as many as 5 years of service. This challenge underscores the importance of improving communication between school district and program staff, especially in cases in which employee turnover creates gaps in knowledge about existing systems. In the future, program leaders plan to proactively reach out to new special education directors to formulate a plan for minimizing disruptions to students if any provider changes are under consideration. In addition, Special Education Local Plan Area leaders have recently organized conflict resolution meetings between SBMH and special education staff.

Finally, program leadership reported that more students and their families have struggled with the economic and health impacts of the COVID-19 pandemic. Program staff have observed an

increase in the number of students with frequent absences during the pandemic, which makes it much more challenging to deliver services. Staff generally raise concerns about student absences during a monthly meeting with school district staff or by calling an ad hoc provider meeting. For students with prolonged absences, clinicians also try to engage with students by setting up telehealth appointments or conducting a home visit.

Demographics

The table below summarizes the demographic information for the 345 clients who were admitted and actively a part of the SBMH program during FY 2021-22.

Age category	Percentage	Race	Percentage
0–15	50.7	Other	35.7
16–25	49.3	White/Caucasian	22.0
26–59	0.0	Multiple	11.3
60+	0.0	Black	4.3
Primary language	**Percentage**	Filipino	3.8
English	65.2	American Native	1.2
Spanish	27.5	Chinese	0.6
Arabic	0.3	Korean	0.3
Other Non-English	0.3	Other Asian	0.3
Korean	0.3	Tongan	0.3
Tagalog	0.3	Unknown / Not Reported	20.3
American Sign Language	0.3	**Ethnicity**	**Percentage**
Other Chinese Language	0.3	Hispanic or Latino	49.6
Unknown / Not Reported	5.5	Not Hispanic or Latino	34.8
Sexual orientation	**Percentage**	Unknown / Not Reported	15.7
Straight or heterosexual	26.4	**Sex assigned at birth**	**Percentage**
Decline to state	9.0	Female	31.9
Another	2.0	Male	68.1
Bisexual	1.7		
Lesbian or gay	1.4		
Queer	0.3		
Unknown / Not Reported	59.1		

CRISIS COORDINATION

The crisis manager of the Crisis, Outreach, and Engagement team at BHRS manages four programs: Assisted Outpatient Therapy (AOT), Psychiatric Emergency Response Team (PERT), Healthcare for the Homeless (HCH), and Homeless Engagement Assessment and Linkage

(HEAL). The role was established about 3 years ago by the deputy director of Adult/Older Adult Mental Health Services who restructured these programs to report to one manager. This role includes responsibilities around developing and supporting new grant funding opportunities related to crisis response services, outreach, and engagement. The current crisis manager has been in the role since March 2022.

The crisis manager's responsibilities include overseeing the program, delivery, and services of the four programs. The purpose of these programs is to conduct crisis response services as well as outreach and engagement under BHRS. The crisis manager's responsibilities include attending larger and separate teams' meetings as well as addressing personnel issues. Their responsibilities also include partnering and interfacing with the public and coordinating with other partners or systems in refining and developing processes and new services to address crisis needs in the community. One recent example of this is participating in the development and implementation of the 988 Suicide and Crisis Lifeline promotion and protocols for the county. There have also been new initiatives under Crisis, Outreach, and Engagement related to the homeless population in the county (e.g., addressing the homeless population's needs within the Leveraging Equal Access Program [LEAP]). The crisis manager partners with other systems to ensure there is a unified response in delivery of mental health crisis and follow-up services to this population.

As previously mentioned, the crisis manager's role includes participating in, developing, and leading grant funding opportunities that may not necessarily tie directly to the four programs they manage; however, these opportunities add to the continuum of care. Once grants are awarded, the crisis manager then oversees core aspects of the contracts including reviewing the contracts, meeting with the leadership of the contracts/contractors, and making sure that the deliverables of the contracts are being achieved.

The crisis manager interacts with many other teams within BHRS and is unique in that they interact with both adult and youth-focused programs, populations, and both adult and youth team leadership, managers, supervisors, and program specialists. In addition to this, whenever a new crisis case may impact an existing BHRS client, the crisis manager will interact with the team addressing the crisis case including the manager and supervisor.

Program Impact

The crisis manager's vision aligns with the BHRS management vision about crisis services in San Mateo County. This includes continuing to improve in their ability to provide timely response to behavioral health crises for all youth and adults in San Mateo County regardless of their insurance status as well as provide quality care and needed follow-up on those services. The crisis manager strives to continue to provide crisis services in a timely, respectful, and culturally responsive person-centered manner. All behavioral health crisis programs would also be coordinated for easy access and uniformed standards of care across all programs.

Successes

The crisis manager has experienced many successes tied to increased communication and collaboration this past year. One success has been around the Crisis Care Mobile Unit Grant, a new grant that had started before the manager's time. The agreement had been pending execution, but the manager had been able to push the application and execution forward and contract with a consultant to support the work. Since execution, they have been able to hold multiple stakeholder feedback sessions throughout the county with the community. It has been fulfilling to share the current crisis response services with the community as well as connect with all services and systems that are assisting in planning for the mobile unit.

Another success experienced this past year is related to enhancing collaboration with the school district and county office of education. The crisis manager has been able to consistently attend the safe school coalition meetings, and the crisis staff also rotate in attending the student threat assessment team meeting. In the latter, many systems come together to work on coordinating care plans for a student. The crisis team contributes to the plan by using its behavioral health expertise in terms of understanding issues related to mental health, family dynamics, etc.

The crisis manager has also experienced success in tightening up collaboration between AOT and the Full Service Partnership specifically around the new Senate Bill 317 by having monthly meetings with these teams. This collaboration has helped in closing communication and care coordination loops among these programs.

Challenges

One challenge that has affected the crisis program effectiveness has been staff vacancies. A couple of the current positions are "extra help on limited-term" positions, which make it challenging to encourage staff sustainability, morale, and commitment. This factor has also affected the program's ability to achieve certain program expectations. For example, vacancies on the HEAL team have resulted in the program having less clinician coverage within the county than previously expected. One way the crisis manager has been mitigating this challenge has been to promptly and effectively communicate their ability to meet expectations to the county and outside partners. The crisis manager also plans to continue to advocate for the creation of job listings and filling of positions, although they noted they have a supportive director and health chief who are aware and understanding of this challenge. They plan to continue to support the supervisor of the crisis teams and their staff by listening to their concerns, helping problem solve, and giving positive reinforcement.

Another challenge that has affected the crisis manager's ability to properly oversee programs has been unforeseeable requests and demands that may come through that they need to address in a timely manner. This includes new grant opportunities to expand services with existing limited staffing resources.

PEER SUPPORT WORKERS & FAMILY PARTNERS

San Mateo County BHRS continues to support Peer Support Workers and Family Partners employed throughout the Youth and Adult Systems. These workers provide a very special type of direct service and support to BHRS consumers/clients. They bring the unique support that comes from the perspective of those experiencing recovery, either in their own personal lives, or as relatives of someone personally affected. They know firsthand the challenges of living with and recovering from a behavioral health diagnosis and work collaboratively with the clients based on that shared experience.

Program Impact

Peer and Family Partners	FY 2021-22
Total clients served	123
Total cost per client	$12,634

There are 9 Peer Support Worker positions in the BHRS adult system funded by MHSA. They are distributed throughout the system in a variety of clinical program teams: OASIS (Older Adult system of Integrated Services), Pathways and the 5 County Regional Clinics. One part-time Peer Support Worker position was made full time.

- 6 Peer Support Workers on the Adult Clinical Services Teams
- 1 Peer Support Worker is in the Older Adult System of Integrated Services (OASIS) Team (part time civil service position)
- 1 Senior Community Worker on the Adult Services Teams (full time civil service position)
- 1 Senior Community Worker on the Pathway Team (full time civil service position)

The Peer Support Workers are culturally, racially, ethnically and linguistically diverse. This includes Chinese, Pacific Islander, Latino, Caucasian, African American and LGBTQ staff, several of whom are immigrant bilingual and bi-cultural.

- Facilitate the transition to a higher level of care
- Connecting to vocational resources
- Applying for benefits, process with Medi-Cal, Supplemental Security Income (SSI), unemployment Social Security Disability Insurance (SSDI), Department of Rehabilitation assistance, general assistance, food stamps, etc.
- Providing transportation support in order to acquire medical or mental health services,
- Assisting with the distribution of phones for clients to attend appointments
- Supporting clients with phone technology
- Connecting to virtual peer support services as heart and soul, California clubhouse, Voices of Recovery and the Barbara A. Mouton Multicultural Wellness Center

Trainings FY 2021-22: This fiscal year has been mostly dedicated to the implementation of Senate Bill 803 – Peer Support Specialist Certification. All of the Peer Support Workers have registered either for the Grandparenting process or Initial Certification Process. San Mateo County BHRS contracted with the California Association of Social Rehabilitation Agencies (CASRA) to provide a 60-hour training for new peer support staff:

- 2-hour - Recovery, Wellness and Resiliency Part 1
- 2-hour - Recovery Wellness and Resiliency Part 2
- 2-hour - Nothing About Us Without Us - History of the Treatment of People with Mental Health Challenges
- 2- hour-The Values of Peer Providers
- 2-hour -The Role of Peer Providers
- 2-hour - Listening
- 2-hour - Harm Reduction and the Three E's
- 2- hour - Harm Reduction Part 2
- 2-hour - Culture and Worldview
- 2-hour - Trauma-Informed Care
- 2-hour - Boundaries and Ethics 1
- 2-hour - Boundaries and Ethics 2
- 2-hour - Honest Open Proud: Self-Disclosure and Sharing Your Story
- 2-hour - Honest Open Proud: Self Disclosure and Sharing Your Story Part 2
- 2-hour - An Overview of Psychosocial Rehabilitation
- 2-hour - Being a Navigator and Making Good Referrals
- 2-hour - Supported Education
- 2-hour - Supported Employment

In addition, the Peer Support Workers also completed:

- 10-hour documentation training for Peer Support Workers and Family Partners
- COVID-19 Prevention Program (CPP) Training
- Digital Health Literacy Training and Technical Support; Introduction to Digital Peer Navigation/ Smartphones; Email Set-up and Maintenance; Online Security and Privacy; and Telehealth during COVID-19
- Painted Brain's Community Tech Café to learn about today’s most important uses of technology to stay connected with work, family, and friends.
- Working Effectively with Limited English Proficient Clients and Interpreters Training
- BHRS Confidentiality and HIPAA for Mental Health and Alcohol and Other Drug services
- NMT - 14 hours Training
- Compliance Training for BHRS
- Fraud, Waste, and Abuse Training for BHRS

Peer Support Workers bring their lived experience to the broader community by participating in community groups and County BHRS Health Equity initiatives such as:

- African American Initiative
- Lived Experience Speakers Academy
- Lived Experience Education Workgroup
- Housing Operations and Policy Committee
- Housing Change Agent Meeting
- MHSA Steering Committee

Peer Support Workers retreat was in person in Half Moon Bay. This retreat was key for the integration of the new peers in the group. The first half of the retreat they reflected on the last two years and are looking forward to the Peer Support Specialist Certification and how it will professionalize the role they have on their different teams and the system. Each Peer is at a different stage with the process. The second half of the retreat was dedicated to self-care and getting to know each other.

Successes

The program saw successes as a response to efforts with new COVID-19 protocols:

- Staff continue encouraging client engagement with virtual services and reaching out to clients in between appointments, assessing their needs and providing resources.
- Support in getting consumers/clients to vaccination clinics.
- Support and distribution of electronic devices to consumers/clients to continue engaging in their treatment goals and participate in activities provided by San Mateo County peer run organizations**.**
- BHRS has contracted and provided a 60-hour Peer Support Specialist Training for Peer Support Workers in preparation for the implementation of Senate Bill 803 in July 2022 with CASRA.
- BHRS also has contracted a 12-hour Documentation Training for Peer Support Workers.

Challenges

- A high percentage of unvaccinated BHRS clients and youth 12 and over, despite the outreach efforts to raise awareness on the importance of getting vaccinated.
- Effects of isolation and fear of getting sick during COVID-19 on the mental health of clients.
- Housing - keeping their housing and supporting clients to meet and get requirements for a mainstream voucher or other housing vouchers—food resources and applying for government grants for those qualified, such as Immigrant Families Fund.
- The inability to hold in person groups for clients caused challenges for the program.

Demographics

	FY 2021-22		FY 2021-22

Primary Language		Sex Assigned at Birth	
English	17%	Male	24%
Spanish	80%	Female	74%
Mandarin	1%	Decline to state	1%
Tagalog	1%	Gender Identity	
Another language	1%	Male/Man/Cisgender	25%
Age		Female/Woman/Cisgender Woman	70%
0-15	9%	Transgender Woman	1%
16-25	3%	Decline to state	3%
26-59	86%	Sexual Orientation	
60+	2%	Gay, lesbian, homosexual	0%
Decline to state	1%	Straight or heterosexual	84%
Race/Ethnicity		Questioning or unsure	2%
Asian	2%	Decline to state	14%
Black/African-American	2%	**Veteran**	
White/Caucasian	3%	Yes	2%
Mexican/Chicano/Hispanic/Latinx	56%	No	95%
Asian Indian/South Indian	1%	Decline to state	2%
Fijian	1%		
Central American	14%		
Chinese	1%		
Filipino	3%		
Puerto Rican	1%		
Samoan	1%		
South American	9%		
Another race/ethnicity	8%		

CLIENT STIPENDS

Individuals with lived experience engaged in planning, implementation and evaluation activities. Participation and expertise of individuals with lived experience is promoted and compensated with stipends. For the FY 2021-22 reporting year of the enclosed MHSA Annual Update, the following stipends were provided to clients and family members of clients participating in MHSA-funded activities.

Activity (FY 2021-22)	Stipend $ Amount Distributed	# Unique recipients
Health Equity Initiatives	$5,700	36
Help@Hand – Wysa	$2,820	20
MHSA FSP	$360	4
Lived Experience Education Workgroup	$4,230	26

Women's Conference	$1,020	6
Advocacy Council	$2,790	14
Advocacy Academy	$2,040	9
Mental Health Awareness Month	$390	9
MHSA Steering Committee	$90	3
Diversity and Equity Council	$600	6
Suicide Prevention Planning	$1,800	14
TOTAL	$21,840	

THE BARBARA A. MOUTON MULTICULTURAL WELLNESS CENTER

The Barbara A. Mouton Multicultural Wellness Center (Mouton Center) provides behavioral health clients and their family members, culturally diverse community-based programs, support and linkages to services and resources as needed in the East Palo Alto community. To that end, the program creates a safe and supportive environment for adults with mental illness and/or co-occurring addiction challenges and their families who are multiracial, multicultural and multigenerational through various strategies.

The Mouton Center:

- Reduces stigma and discrimination - through Mental Health First Aid (MHFA), culturally responsive peer support groups, Wellness Recovery Action Plan (WRAP) groups, etc., stigma and discrimination is addressed with participants by facilitating discussions about mental health. Understanding results in empathy and authentic concern for those suffering with a mental illness and empowers them to speak-up on behalf of others.
- Increases number of individuals receiving public health services - The Mouton Center staff facilitate connections between people who may need mental health and/or substance use services or other professional services to relevant programming and/or treatment by conducting the following:
- Performing initial screening and engaging potential clients
- Providing brief interventions to motivate more extensive assessment and intervention
- Referring members who may need behavioral health services to appropriate agencies in the behavioral health system of care for assessment and follow up treatment as needed.
- Reduces disparities in access to care- The Mouton Center opened its doors in June 2009 to reduce the disparities in accessing mental health services in East Palo Alto as well as to reduce the stigma associated with mental health. To this end, The Mouton Center has been a safe haven for consumers to gather, pursue leisure activities and be in community with one another without judgement. The program has been the connection to mental health services for the consumers and through its programs, services and classes reduce disparities in access to care and the stigma associated with being identified as one needing mental health services.

Program Impact

Mouton Center	FY 2021-22
Total clients served	107
Total cost per client	$1,890

Outreach activities at the Mouton Center:

- Most frequently took place in unspecified locations (78.4%; *n* = 29).
- Were conducted in English (81.1%; *n* = 30), Tongan (16.2%; *n* = 6), and Mandarin (2.7%; *n* = 1).
- Resulted in 35 mental health referrals and no substance use referrals.
- Resulted in one social service referral for medical care.

Outreach event attendees:

- Most were female (56.8%; *n* = 21); 43% were male (43.2%; *n* = 16).
- Identified as female (56.8%; *n* = 21) or male (43.2%; *n* = 16).
- Identified as heterosexual (97.3%; *n* = 36) or queer (2.7%; *n* = 1).
- Were adults (26–59 years of age, 56.8%; *n* = 21), older adults (60 years of age and older, 40.5%; *n* = 15), or transition-age youth (16–25 years of age, 2.7%; *n* = 1).
- Were primarily White (40.5%; *n* = 15), Tongan (16.2%; *n* = 6), or Asian (16.2%; *n* = 6).

Demographics

	FY 2021-22
Race/Ethnicity	
Asian	16.2%
Black/African-American	0%
White/Caucasian	40.5%
Mexican/Chicano/Hispanic/Latinx	5.4%
Chinese	5.4%
Filipino	2.7%
Puerto Rican	2.7%
Samoan	5.4%
Tongan	16.2%

In FY 2021-22, three attendees at the Mouton Center reported being in special population groups. Of the three, one was at risk of homelessness, one had other chronic health conditions, and one had a physical/mobility disability.

CALIFORNIA CLUBHOUSE

California Clubhouse is a community-centered organization where adults (18 years and older) with mental health challenges can go every day during business hours to work on overcoming obstacles they face. It offers support, training, education, employment, healthy social interactions and positive reinforcement through collegial relationships and work. California Clubhouse is currently hosting 40 plus hours of Hybrid Programming, Monday thru Friday from 8:30am to 5pm as well as weekly virtual and in-person social gatherings.

Members (program participants) share ownership and responsibility for the success of the organization. They work and socialize in a unique partnership with small and dedicated staff, building on their strengths. Clubhouse program also builds and supports its members' social and emotional skills and well-being. This community-centered approach meets individuals in their path of recovery and has proven to support successful outcomes.

This last year, California Clubhouse restructured their programming to allow for in-person and virtual (Hybrid) formats. Clubhouse resumed the Hospitality and Business Unit structure after about a year-hiatus. The return to this structure aligned us better to the Clubhouse International Model of Rehabilitation. Colleagues (members and staff) work together to do the day-to-day work associated with maintaining a meaningful and productive program. The work-ordered day highlights the talents and abilities of members and are utilized within the Clubhouse. Members can participate in consensus-based decision-making regarding all important matters relating to the running of the program. They have opportunities to obtain paid employment in the local labor market through a Clubhouse-created Transitional Employment Program. In addition, members participate in Clubhouse-supported and independent employment programs; assistance in accessing community-based educational resources; access to crisis intervention services; evening/weekend social and recreational events; and assistance in securing and sustaining safe, decent and affordable housing.

At California Clubhouse, the work includes, but is not limited to, orientation of new colleagues, tours for potential members and guests, running the meal program, administering employment programs, assistance with educational goals, fundraising, marketing, reach out, planning social activities, and conducting evaluation of Clubhouse effectiveness and policies. The community-centered approached provides members the opportunity to build long-term relationships that, in turn, support them in obtaining employment, education and housing as well as creating a social community outside of Clubhouse hours.

Program Impact

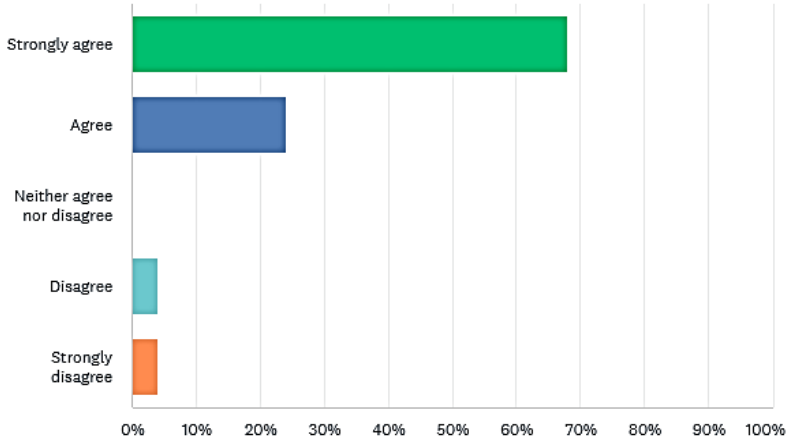
California Clubhouse	FY 2021-22
Total clients served	172
Total cost per client*	$1,943

As the Clubhouse International website states, “Clubhouses are a powerful demonstration of the fact that people with mental illness can and do lead normal, productive lives.” Many members in the community speak of the ripple effect the Clubhouse has on their personal lives. Stories have been shared that after attending the Clubhouse program, members were able to rebuild and strengthen relationships with family members and friends, felt motivated to return to school or paid employment, and noticed an increase in independence. Through active and frequent participation, members integrate into a supportive community where they can build meaningful relationships with peers while working together. Naturally, as relationships grow, opportunities for peer support and socializing increases alongside the members’ self-esteem. A member becomes a part of a greater community that truly cares for each other’s health and well-being. If it is noticed that a member is struggling on any day, the unit rallies around the individual by conducting a reach out call, sending a greeting card or inviting them on Zoom. When someone begins to isolate, the unit quickly finds ways to engage them and pull them closer into the community and/or refer them to County services and other Community Based resources.

Key indicators in the member satisfaction survey are as follows:

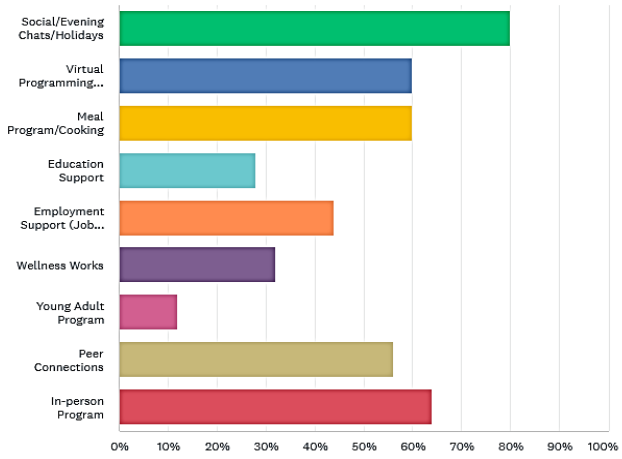
I belong to a supportive community at California Clubhouse.

Answered: 25 Skipped: 0



What brings you back to California Clubhouse on a regular basis? (select all that apply)

Answered: 25 Skipped: 0

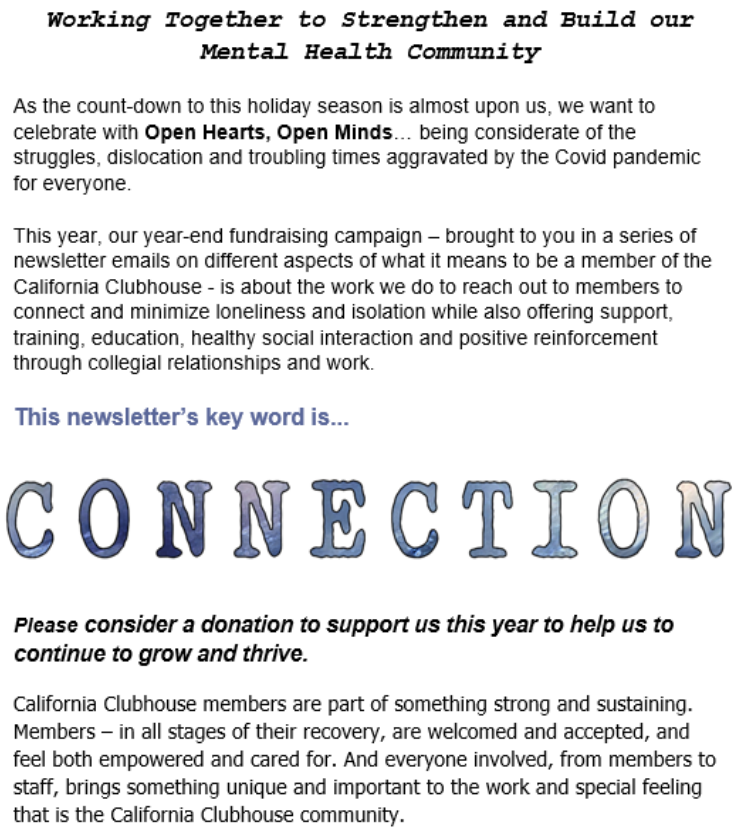


Additionally, participants were provided the opportunity to answer how their quality of life has improved since joining the Clubhouse, respondents reported 83.33% increase in social relationships, 70.83% increased independence, 62.5% reduced hospital visits, along with 50% increase treatment/medication compliance.

Successes

The following is an excerpt from the California Clubhouse End of the Year email campaign that showcased the impact the Clubhouse has had on members and staff:

> Built upon proven standards for best practices, California Clubhouse understands that working together creates community in powerful and sustaining ways. The Clubhouse International quality standards promise that membership is free, voluntary and without time limits.... And that members are always invited to participate fully in programs, activities and leadership.
>
> In real life, this model empowers members to both give and receive. "Clubhouse helps us understand that you need to work as a team if you are going to get anywhere," explains Peter, a California Clubhouse member. "It doesn't matter what we work on, we work together."
>
> At the Clubhouse all meetings are open to both members and staff—and program decisions and member issues are discussed and decided upon. Nothing happens at the Clubhouse without member involvement—and that's healing in and of itself. "We are acknowledged as people and not as our diagnosis," says Hansel, a new member since Covid began.



Working Together to Strengthen and Build our Mental Health Community

As the count-down to this holiday season is almost upon us, we want to celebrate with **Open Hearts, Open Minds**… being considerate of the struggles, dislocation and troubling times aggravated by the Covid pandemic for everyone.

This year, our year-end fundraising campaign – brought to you in a series of newsletter emails on different aspects of what it means to be a member of the California Clubhouse - is about the work we do to reach out to members to connect and minimize loneliness and isolation while also offering support, training, education, healthy social interaction and positive reinforcement through collegial relationships and work.

This newsletter's key word is…

CONNECTION

Please consider a donation to support us this year to help us to continue to grow and thrive.

California Clubhouse members are part of something strong and sustaining. Members – in all stages of their recovery, are welcomed and accepted, and feel both empowered and cared for. And everyone involved, from members to staff, brings something unique and important to the work and special feeling that is the California Clubhouse community.

Challenges

Similar to last year, there was yet another year, without the proper implementation of a meal program. The Clubhouse was unable to serve any meals through all of the pandemic. This year, the Clubhouse wanted to do something around the meal program. So, as the building opened more and more for programming, planning for creative and safe ways to serve lunch at the Clubhouse began.

- The Hospitality Unit came together to research, budget, and plan for the new meal program.
- A Square Point of Sale system was purchased to allow for purchases made with credit cards or contactless and limit exchange of money.
- Members and staff planned weekly shopping trips to purchase meal items. This process included analyzing number of meals typically served, and which items were selling faster.
- Create meal options that would be sold during the lunch time (11:30am-1pm) at a more equitable price. A ham/turkey sandwich or salad with a side of chips for $3.00. After the lunch time, the items were sold separately at different prices to offset the cost. The Clubhouse would not be breaking even and were comfortable with that.
- Revamped Brian's Café by adding new items such as protein packs, tea and k-cup coffee.

In-person gathering for the holiday season was deeply affected by the pandemic. Not celebrating as a community was not an option. Therefore, the Clubhouse researched the most affordable restaurant to

cater meals from and did a mass Dollar Tree run to purchase stockings and stocking items. The community was informed about the holiday plans by conducting mass outreach such as postcards, phone calls and text messages. It was decided that any active member in the last year would be receiving a Holiday stocking from the Clubhouse and that, those that reserved a spot, would be getting a hot meal. Clubhouse members, staff, volunteers, and the board were rallied to support in delivering Holiday meals and stockings to over 130 members and staff for dinner. Meetings were virtual via Zoom to enjoy the meal together, open gifts and spend some time as a community – no work-talk allowed.

Demographics

	FY 2021-22		FY 2021-22
Primary Language		**Sex Assigned at Birth**	
English	65%	Male	40%
Spanish	1%	Female	28%
Another language	1%	Decline to state	2%
Age		**Gender Identity**	
0-15	0%	Male/Man/Cisgender	40%
16-25	2%	Female/Woman/Cisgender Woman	28%
26-59	73%	Transgender Male	0%
60+	24%	Genderqueer/Nonconforming	1%
Decline to state	1%	Questioning/ Unsure	1%
		Decline to State	2%
Race/Ethnicity		**Sexual Orientation**	
Asian	9%	Gay, lesbian, homosexual	1%
Black/African-American	7%	Straight or heterosexual	54%
White/Caucasian	41%	Queer	1%
American Indian/Alaska Native/ Indigenous	5%	Pansexual	1%
Mexican/Chicano/Hispanic/Latinx	4%	Bisexual	5%
Arab/ Middle Eastern	1%	Another sexual orientation	1%
Central American	1%	Decline to state	7%
Filipino	4%		
Puerto Rican	1%	**Veteran**	
Samoan	1%	Yes	3%
Tongan	1%	No	91%
Japanese	1%		
Korean	1%		
Vietnamese	1%		
Another race/ethnicity	1%		

PRIMARY CARE INTEGRATION

PRIMARY CARE INTERFACE

The Primary Care Interface (PCI) program is funded 20% CSS, 80% PEI. PCI integrates mental health services within primary care. The program partners with San Mateo County primary care clinics to provide easier access to mental health services. The program started in 1995 at one clinic and is now embedded in five different primary care clinics throughout the county. Since its inception, the program staff grew from one therapist and nurse to a multidisciplinary team with more than 23 staff who are marriage or family therapists, licensed clinical social workers, and case managers. Originally PCI was 100% funded by the PEI component of MHSA but, this changed due to the nature of the work and demand and about 20% of clients with severe mental illness receive treatment directly from PCI.

In FY 2021-22, the PCI program served 2,500–3,000 clients in San Mateo County. Clients are mostly referred out, based on their needs, into psychiatry, therapy, case management, or all three in some cases. The PCI program also provides direct substance use counseling.

Program outcomes are included in the PEI section of this report.

INFRASTRUCTURE STRATEGIES

Infrastructure strategies funds BHRS administration, information technology (IT), support staff, evaluation consultants, and the Contractor's Association.

CONTRACTOR'S ASSOCIATION

The Contractor's Association Grant Funding program exists to fund organizations that contract with BHRS to be able to:

- Improve capacity to provide integrated models for addressing trauma and co-occurring disorders.
- Improve its capacity to incorporate evidence-based practices into day-to-day resources.
- Improve its cultural competency; and
- Improve its capabilities to collaborate, partner and share resources and information with other Association Members.

Caminar acts as the fiscal agent, oversight and accountability to this program. See Appendix 12 for the data on each funding recipient and what needs were met.

OUTREACH AND ENGAGEMENT (O&E)

The Outreach and Engagement strategy increases access and improves linkages to behavioral health services for underserved communities. BHRS has seen a consistent increase in representation of these communities in its system since the strategies were deployed. Strategies include pre-crisis response, and primary care-based linkages.

FAMILY ASSERTIVE SUPPORT TEAM (FAST)

The Family Assertive Support Team (FAST) is an in-home outreach and support services program. FAST's purpose is to assess, educate, assist, support, and link families and adult mental health/substance use consumers that are living with their family (two or more people with close and enduring emotional ties) to appropriate mental health and substance use services and a myriad of other resources and opportunities suitable to the individuals' needs and goals.

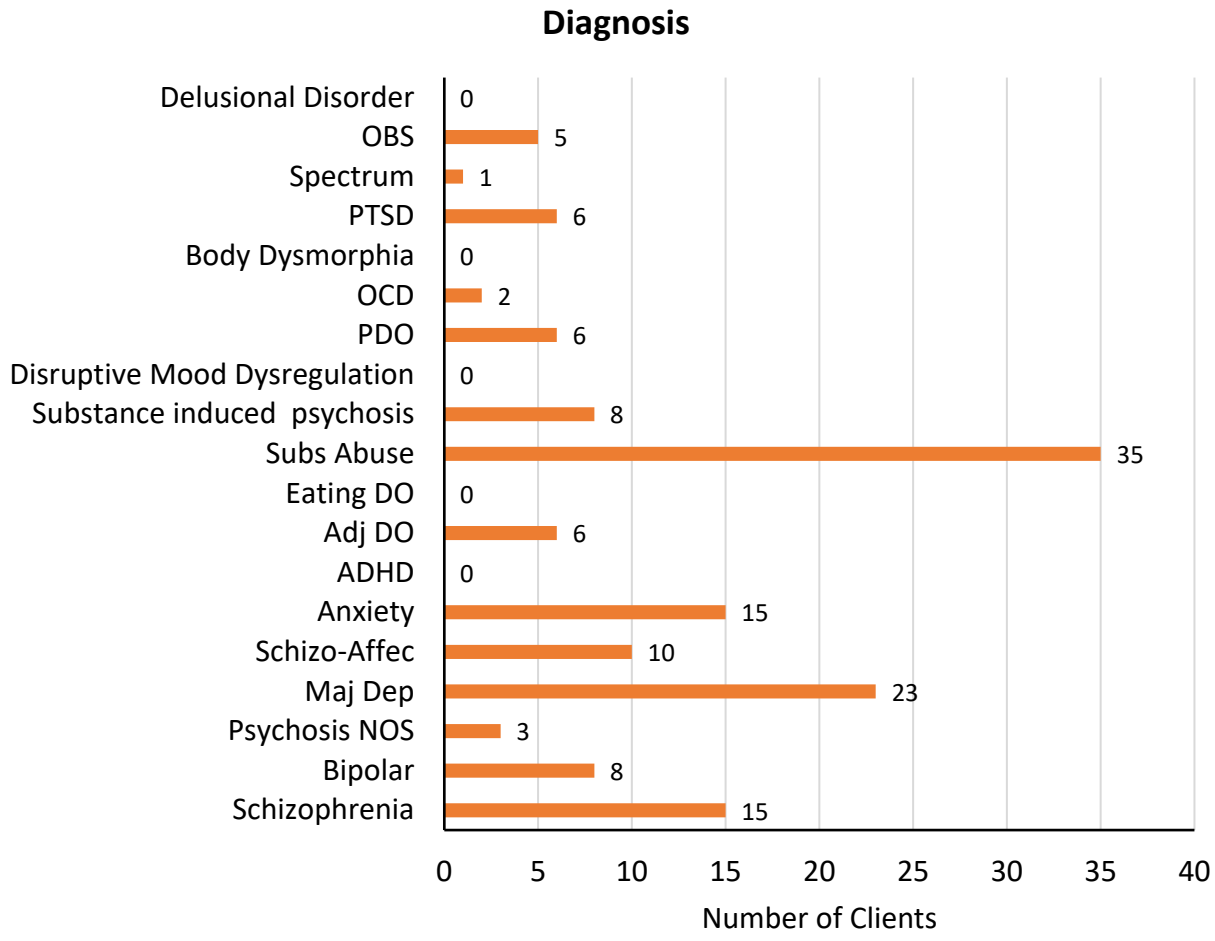
Program Impact

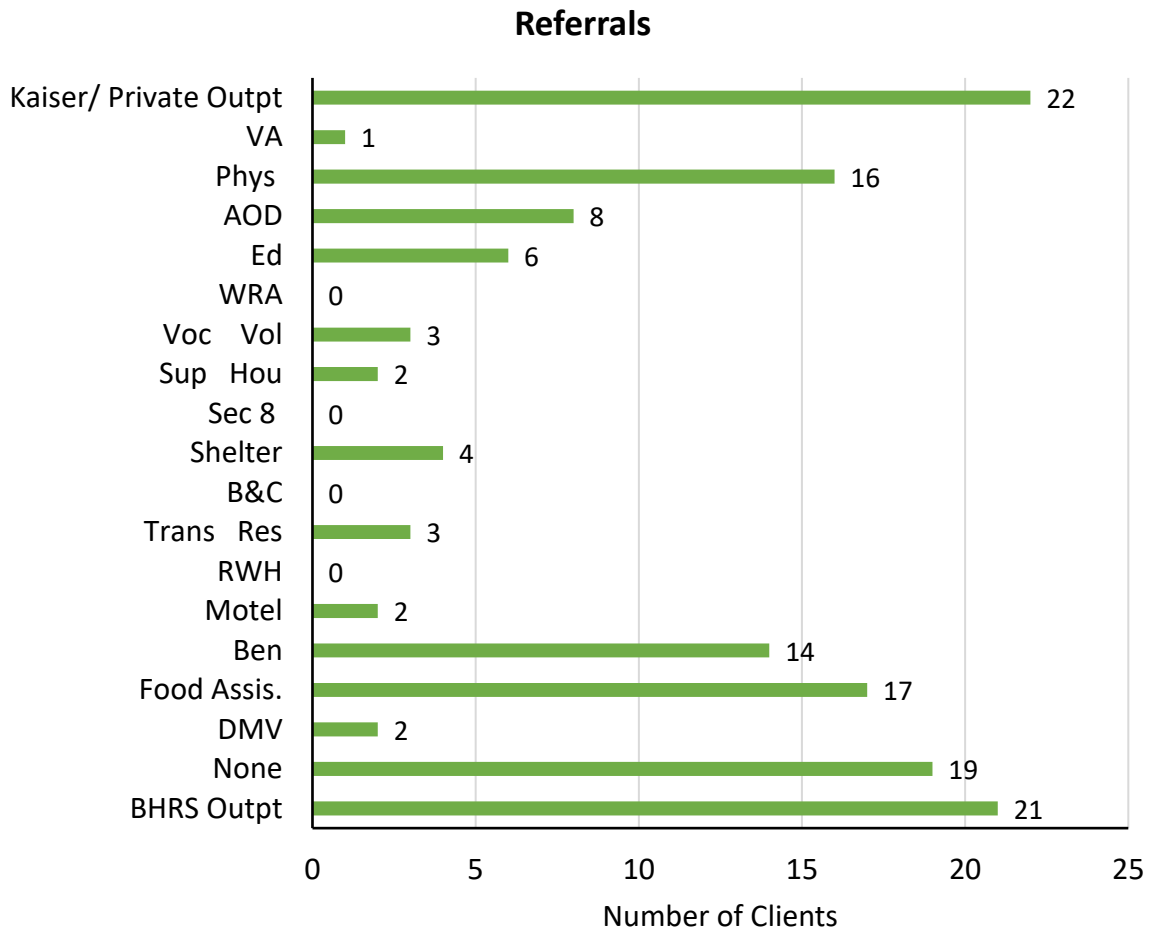
Pre-Crisis (FAST)	FY 2021-22
Total clients served	76
Total cost per client	$4,501

FAST collects the following data: age, gender, diagnosis, Level of Care Utilization System (LOCUS) score, county region, ethnicity, referral source, type of contact, referral outcome, prior connection to mental health services, pre and post hospitalization/jail contact. There were 76 clients served by FAST in FY 2021-22. With 100% diagnosed. Of these there were zero homicides and zero suicides. The rate of hospitalization and incarceration were higher pre-contact with FAST and significantly reduced-post contact. Zero post-FAST were incarcerated.

Additionally, of the 76 clients, 59 of them had zero contact or current connection with outpatient mental health services Prior to FAST. 52 clients were successfully connected to outpatient mental health and substance use services, post FAST contact. And the majority of those not connected, were however connected to some level of social services, benefits, housing, medical services, etc. The collected locus scores indicate majority of clients had SMI with significant disability and in need for behavioral health treatment and adjunct services post FAST. The ethnicity of clients served would appear to reflect demographic distribution not far from the averages of the San Mateo County. The ages of FAST clients were a good spread between young adults and geriatric, but younger adults predominated. The negative outcomes and concomitant suffering for individual and family alike were diminished from contact with FAST: Psychoeducation and proper linkage to appropriate services. The few who refused to get

into needed treatment, will likely resurface and another opportunity for FAST to connect them to outpatient services or ancillary services will present itself.





Successes

Success Vignette: “Conrad”: “When I met him, ‘Conrad’ had been around the world, literally, in search of the meaning of his life, a spiritual and healing quest. He had been accepted to an elite military academy university, as an elite athlete and scholar. He had ambitions and high likelihood of becoming a fighter pilot with a long career in the military based on aptitude and past academic performance. Life altering injuries on the sports field had made it impossible to continue on this trajectory and he had to resign his commission. After graduating from another top tier university, he pursued the business and banking industry while also developing his art. Conrad was violated by a trusted mentor while developing his artistic skills and ambitions, and his life began to unravel precipitously. The losses of his athletic, military, artistic dreams and unresolved personal traumas, propelled him to seek existential answers to his existential questions. Global travel to remote outposts, long and extreme fasting and meditation, prodigious and prolonged ingestion of psychedelic plants and shamanic practices, had taught him many things, but he also became quite psychologically disorganized and distressed and couldn’t relate well to his family, friends, nor ‘consensual reality’ successfully. There was much confusion, anger, sadness, anxiety, depression, unresolved trauma. He also had acquired

debilitating medical problems. He couldn't work or socialize due to his manifold symptoms, hence furthering his sense of alienation. With many prompts and attempts from his loving family to cajole him home from abroad and to connect with FAST, to see if FAST could help, he boarded a plane back home and accepted the outreach from FAST. This personal connection began his journey toward healing. Through FAST, Conrad obtained Evidence Based Therapy (EBT), General Assistance and connection to BHRS Psychiatry/Counseling, Primary Care Medicine, LGBTQ+ community support, Veteran Administration benefits counseling. Conrad is currently in the process of working with FAST and the State Voluntary Service Overseas representative to establish veterans' benefits beginning with his time in service and initial injuries, the antecedent to the chain of events that effected his life trajectory so profoundly. Conrad is diligently participating in his own rescue and recovery. He is an outstanding person in every respect and has been most gratifying and exciting to me professionally and personally to work with and help. His family reports, in essence, that they are very grateful to have their son and brother back again from the outer edges of the globe and human experience. Although he may not have become a fighter pilot, on his current trajectory, the 'sky is the limit' on what he can and I'm sure he will achieve." -Matt Sweeny

Challenges

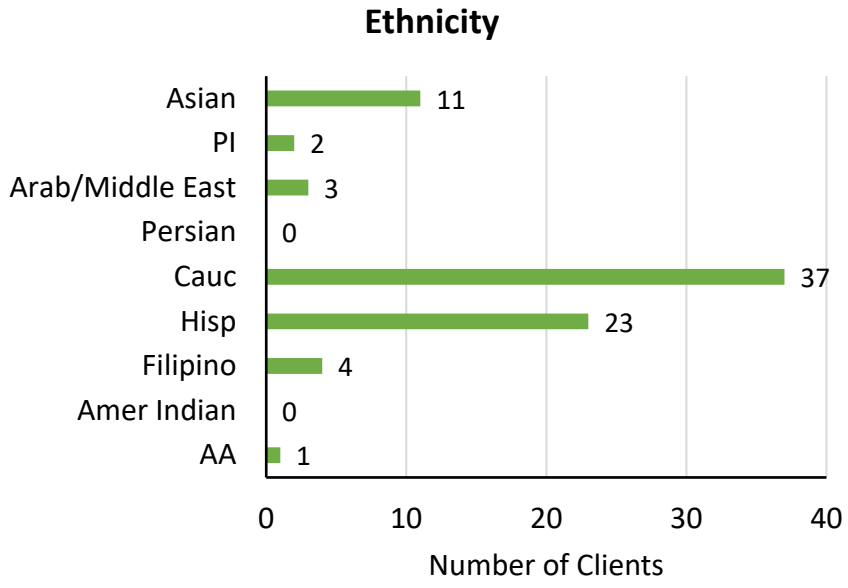
FAST has faced several challenges throughout the FY 2021-22

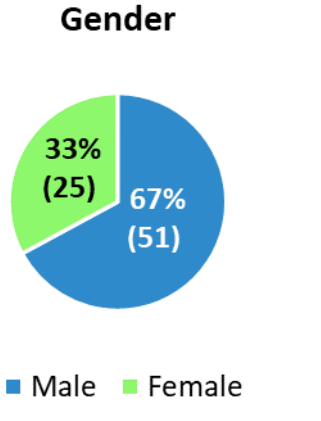
One challenge in the work of FAST, is the symptom of anosognosia, "the inability or refusal to recognize a defect or disorder that is clinically evident". This is something that FAST encounters regularly in its work. *It is* expected and understandable, but the biggest challenge or impediment to successful outcomes for FAST is premature discharge from inpatient hospitalization (5150) while the client is seriously impaired as well as discharge without a coherent and cogent discharge plan. This *is Not* understandable, seemingly unethical and sometimes dangerous. It is also not fiscally prudent as these clients get repeatedly 5150d and tax the entire system. This leaves some exasperated clinicians, paraprofessionals and families alike, usually after many hours orchestrating such an intervention. This repeatedly happens despite FAST consultation and recommendations to hospital personnel and imploring from the families of said clients. Peninsula area Hospital PES's need to rethink their policies and protocols. The human as well as financial cost is too high. Solutions to this conundrum would have to be evaluated by top level behavioral health policy makers and hospital administrators with input by a committee of concerned clinicians, paraprofessionals, family members and community leaders.

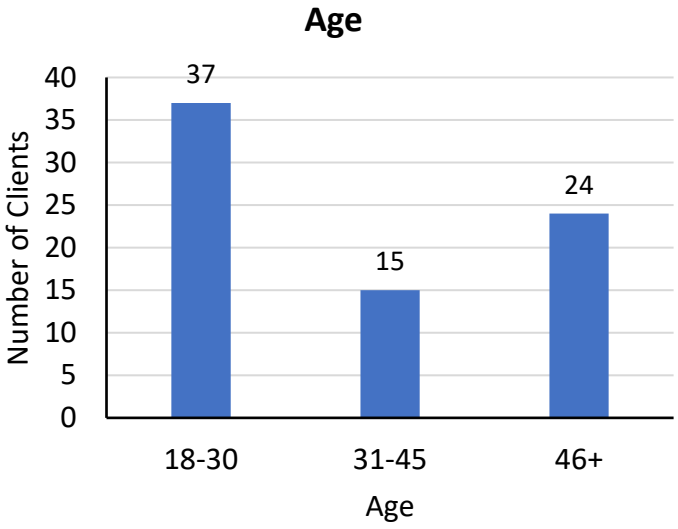
The second challenge FY 2021-22 has been difficult for FAST to improve upon its former accomplishments of the past. The specter of COVID 19 has continued to limit the ability to effectively function in the field (where FAST mainly operate) due to inherent dangers of the COVID virus and its spread, as well as some families and clients not wishing personal contact and due to the innate risks. Despite this challenge, and having COVID diagnoses amongst staff, FAST has persevered and had a successful year by any measure.

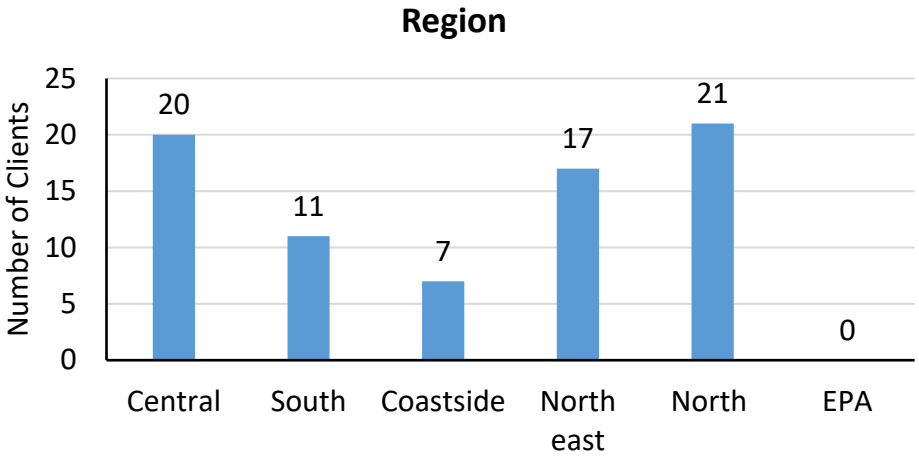
Lastly, "Same Day Access" truly a misnomer at best. FAST's experience with BHRS "Same Day Access" has left the program in many challenging predicaments. Clients are mostly not 5150able when FAST outreach, build rapport and begin services, however, they are very symptomatic and need help. When FAST get a client to agree to get treatment, the wait for real treatment is prohibitive. As anyone who has worked in "the field" knows, two of the biggest obstacles to overcome with the SMI are anosognosia and motivation to obtain treatment. The window of opportunity can be small and rapidly changes. "Same Day Access" this fiscal year often meant a phone call to BHRS Access Call Center, same day call back and initial screening, within a week for a more thorough telephonic evaluation, and then up to a month before the client talks to a psychiatrist for a medication consultation. Bridging that gap between first contact with the mental health system and actual treatment by a clinician and physician can be onerous and frustrating for FAST, client and especially the family living with an individual with severe mental illness.

Demographics









THE CARIÑO PROJECT (COASTSIDE MULTICULTURAL WELLNESS)

The Cariño Project is funded 80% CSS, 20% PEI. The program opens pathways for increased services on the Coastside, limited in services. Counseling services include crisis counseling, family counseling, and counseling at schools, local churches and community spaces. A home visiting model is often used to serve families. Ayudando Latinos a Soñar (ALAS) is committed to meeting the client where they are, both emotionally and physically.

In FY 2021-22, the Cariño Project served 355 unique clients in San Mateo County through their clinical component (therapy and case management). 1,434 individuals (duplicated) were also engaged through various services including groups, training, arts activities and other supports.

Program outcomes are included in the PEI section of this report.

ADULT RESOURCE MANAGEMENT

The Adult Resource Management (ARM) outreach and support services team works in collaboration with Psychiatric Emergency Services (PES) and Psychiatric Inpatient Services at San Mateo County Hospital, the Maguire Facility/Jail, Mental Health Association Spring Street Homeless Shelter, Shelter Network's shelters, Palm Avenue Detox (operated by Horizons Services), and the Mateo Lodge Mobile Support Team. The team will provide early identification, engagement, and case management services to seriously mentally ill (SMI) adults who are homeless or at risk of becoming homeless[2].

The aim of the ARM program is to provide trauma-informed and culturally responsive mental health support to adult clients who are homeless or at risk of becoming homeless, are SMI, have co-occurring substance use or medical conditions, and are in need of the County's mental health in- and out-patient resources and psychiatric care. This support consists of case management provided by the team's Mental Health Counselors (MHCs) out in the field. The team is comprised of four MHCs who work in the community throughout San Mateo County. As part of a Substance Abuse and Mental Health Services Administration (SAMHSA) block grant, the referrals are reviewed by the ARM supervisor for the Intensive Case Management (ICM) referrals, and the referrals from San Mateo County PES and the Facilities Utilization Management (FUM) team approve referrals to the ARM team for the Mental Health shelter beds, Crisis Residential, and the Social Rehabilitation facilities. Each MHC is assigned one or more specific subunit task.

ICM/Outreach and Support
All four MHCs are assigned to this subunit. Referrals focus on clients who are being discharged from psychiatric hospitals and mental health rehabilitation centers (MHRCs) and are in temporary need of ICM support until other community resources can take over such as a Full-Service Partnership (FSP) or a regional clinic case manager. The ARM team also receives referrals from regional clinics that need field support for clients who are at high risk for re-hospitalization.

Maple Street and Safe Harbor Liaison
Two of the four MHCs are assigned to be the liaison of either Maple or Safe Harbor Shelter. If no other outpatient-based team is assigned, they will provide intensive field case management. Otherwise, they will function as the liaison between the shelter and other county mental health programs and resources, such as FSPs or a regional clinic's embedded FSP counselor.

PES/Alcohol and Other Drugs (AOD) Services Coordination
Two of the four MHCs work with clients in need of detox and AOD treatment follow-up and

[2] Criteria for Definition of At Risk of Homelessness - HUD Exchange

linkage. They receive their referrals directly from PES during the morning briefing meetings, and some clients are referred from the community.

Transportation Coordination
MHC and PES staff operate a patient transportation shuttle on a rotating schedule. They provide transport for SMI clients to medical, behavioral health, and court appointments in the community or in addition to any transport between county facilities.

Program Impact

Arm	FY 2021-22
Total clients served	296
Total cost per client	$5,123

Improves timely access and linkages for underserved populations
The ARM program often encounters clients that are difficult to engage but also receive the greatest benefit from timely, comprehensive assessment and support from their initial point of contact with the ARM program staff or partners. In addition, the program has cultural and ethnically diverse staff, some of whom are fluent in Spanish and thus able to provide supportive assistance that is sensitive to client cultural experiences around substance use and mental health topics. The ARM team improves timeliness in linking clients in mental health shelter beds with regional mental health services through critical transport resources or through on-site staff liaisons in shelters who can meet directly with clients and get them in for services. MHCs also link clients with substance use disorders to detox programs.

Reduces stigma and discrimination
Because MHCs are out in the community, engaging with clients and partners one on one on a daily basis, they are able to reduce stigma and discrimination by providing information on the needs of clients and the importance of consistent client support to supervisors, managers, and community organizations and their leadership. The MHCs are client-centered and work to support their clients' unique needs. By witnessing their care locations and dynamics in person, they can better advocate for mental health service modalities and housing and daily living supports that meet their personal context and are equitable or in-line with appropriate standards of care.

Increase the number of individuals receiving public health services
In tandem with mental health, it is a goal to connect clients with primary care services. MHCs work with clients to explore all avenues to receive access to public health services.

Reduce disparities in access to care
For clients who are transient, MHCs connect them to mobile health services. The program also supports clients who are undocumented. These clients face unique challenges related to insurance, specialty health services, and housing subsidies.

Implements recovery principles

The ARM team assists clients who are recovering from substance use disorders. One MHC specializes in this area and can connect clients with the appropriate resources for their recovery such as harm reduction approaches. Staff meet with clients at least once a week, and this high touch point builds rapport quickly. Staff are continuously assessing medically complex clients to see how they can link them to mental health services.

The ARM program is working on the collection and reporting of outcome measures such as employment, housing status, healthcare utilization, and placement location.

Successes

The ARM program continues to pride itself as one of the few teams that has continued to provide field-based services in person despite the COVID-19 pandemic. One of the biggest pieces of the program is the ability to provide services in person, which allows for more frequent touchpoints and support to clients with high needs.

Client Story #1: client of the East Palo Alto (EPA) clinic for emergency shelter found herself homeless after being kicked out of her home. ARM staff coordinated with the client's case manager at EPA and the BHRS housing coordinator and was able to find the client temporary housing at the Industrial Hotel in South San Francisco. ARM staff was able to secure shelter housing at Spring Street Shelter in Redwood City. The client is now living in the transitional housing unit at Spring Street Shelter and is currently working at Goodwill in San Mateo. The client has also been awarded a mainstream voucher and will hopefully be moving into her own apartment within the next 6 months. Coordination with other teams has been a big part of this success story.

Client Story #2: client has been abusing alcohol most of his life. He went through the Laurel House Treatment Program for Drug and Alcohol Addictions and completed the Program late December of 2022. He was placed back at the Pacific Inn Emergency Shelter that is facilitated by Samaritan House. He was able to file for and receive General Assistance benefits and apply for housing. He was accepted by Abode Services who provided assistance, and with the help of a dedicated staff at the Inn, he received housing and is currently living in his 1-bedroom apartment in San Mateo. He was connected to San Mateo County's Vocational Rehabilitation Services (VRS) and started working there. During his application process, his evaluation deemed that he would be of great support working with their kitchen staff because he has experience as a butcher and chef. He is currently working for the VRS kitchen assisting in preparing meals and other duties as needed.

Challenges

Staffing has made it difficult to conduct program activities, specifically field-based support to clients. Another challenge is coordinating with other teams within BHRS and outside contracts.

Client Story: Client at P90/Caminar in San Mateo was doing well in the program; however, upon completion, the job he thought was going to be there for him was not. He had no housing upon completion of the program, so he went to stay at a motel while he could afford it, as his family home was no longer a safe place to return to due to the family's use of alcohol and marijuana. If this client, and others, were able to secure a job and have a place after treatment to go to, this would have assisted that client from discontinuing services with me and the county. When people come out of a treatment program, their self-esteem is still very low, and they are scared and need a secure place to be until they can get back on their feet to provide for themselves for the first time or for the first time in a long time.

Demographics

The table below summarizes the demographic information for the 296 clients who were admitted and actively a part of the of the ARM program during the FY 2021–22.

Age	%	Race	%
0–15	0.0	White/Caucasian	26.4
16–25	7.4	Other	18.6
26–59	77.0	Black	6.1
60+	15.5	Multiple	4.7
Primary language	**%**	Chinese	2.0
English	75.6	Filipino	2.0
Spanish	9.5	American Native	1.0
Tagalog	0.5	Tongan	1.0
Portuguese	0.3	Hispanic	0.7
Unknown / Not Reported	10.8	Hawaiian Native	0.7
Sex assigned at birth	**%**	Korean	0.7
Female	40.5	Unknown / Not Reported	35.8
Male	59.1	**Ethnicity**	**%**
Unknown / Not Reported	0.3	Hispanic or Latino	24.7
Sexual orientation	**%**	Not Hispanic or Latino	49.3
Straight or heterosexual	46.3	Unknown / Not Reported	26.0
Lesbian or gay	4.4		
Decline to state	3.4		
Queer	3.5		
Bisexual	1.0		
Another	0.3		
Unknown / Not Reported	31.4		

HOUSING LOCATOR, OUTREACH AND MAINTENANCE

The Housing Locator, Outreach and Maintenance program will provide housing locator services provided by mental health counselors and peer navigators; the development and maintenance of a new BHRS Housing website with real-time housing availability information; linkages to BHRS case managers; and landlord engagement including community mental health awareness. Outreach and field-based services will be provided to support ongoing and long-term housing retention including a team of Occupational Therapist and Peer Counselor with co-occurring capacity to support independent living skills development.

This program was anticipated to launch this FY 2021-22 but was delayed due to administrative Request for Proposal (RFP) processes delays.

HEAL PROGRAM HOMELESS OUTREACH

The Homeless Engagement Assessment and Linkage (HEAL) program - Homeless Outreach partner certified treatment clinicians with the Homeless Outreach Team (HOT) team and Healthcare for the Homeless (HCH) outreach workers to bring a higher level of direct treatment and case management to the homeless out in the field. The HEAL team provides field-based mental health and addiction treatment, but also case management, referrals, and "warm hand-offs" to the regional health and street medicine services.

In FY 2021-22, two clinicians were hired, outcomes will be provided in the next Annual Update.

THE PRIDE CENTER

The San Mateo County Pride Center (35% CSS, 65% PEI) creates a welcoming, safe, inclusive, and affirming space for individuals of all ages, sexual orientations, and gender identities through education, counseling, advocacy, and support. The Pride Center takes a holistic approach to improving the health and wellbeing of the LGBTQ+ community by providing direct mental health services to individuals living with severe mental health challenges and individuals in the community seeking support groups, resources, community building activities and social and educational programming.

In FY 2021-22, the Pride Center served 169 unique clients in San Mateo County through their clinical component (therapy and case management). 4,456 individuals (duplicated) were also engaged through various services including peer groups, youth and older adult focused services, training, events, outreach and other activities.

Program outcomes are included in the PEI section of this report.

RAVENSWOOD FAMILY HEALTH CENTER

Ravenswood is a community-based Federally Qualified Health Center (FQHC) that serves East Palo Alto residents. Ravenswood provides outreach and engagement services and identifies individuals presenting for healthcare services that have significant needs for behavioral health services. Ravenswood outreach and engagement services are funded at 40% under CSS and the remaining 60% is funded through Prevention and Early Intervention.

The intent of the collaboration with Ravenswood FHC is to identify patients presenting for healthcare services that have significant needs for mental health services. Many of the diverse populations that are now un-served will more likely appear in a general healthcare setting. Therefore, Ravenswood FQHC provides a means of identification of and referral for the underserved residents of East Palo Alto with severe mental illness/serious emotional disturbance to primary care based mental health treatment or to specialty mental health.

Ravenswood	FY 2021-22
Total clients served	544
Total cost per client	$78

PREVENTION & EARLY INTERVENTION (PEI)

PREVENTION AND EARLY INTERVENTION (PEI)

PEI targets individuals of all ages prior to the onset of mental illness, with the exception of early onset of psychotic disorders. PEI emphasizes improving timely access to services for underserved populations and reducing the 7 negative outcomes of untreated mental illness; suicide; incarcerations; school failure or dropout; unemployment; prolonged suffering; homelessness; and removal of children from their homes. Service categories include:

- Early Intervention programs provide treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Services shall not exceed eighteen months, unless the individual receiving the service is identified as experiencing first onset of a serious mental illness or emotional disturbance with psychotic features, in which case early intervention services shall not exceed four years.
- Prevention programs reduce risk factors for developing a potentially serious mental illness and build protective factors for individuals whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members. Services may include relapse prevention and universal strategies.
- Outreach for Recognition of Early Signs of Mental Illness to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.
- Access and Linkage to Treatment are activities to connect individuals with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.
- Stigma and Discrimination Reduction activities reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services.
- Suicide Prevention programs are not a required service category. Activities prevent suicide but do not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness.

PEI REPORTING FRAMEWORK

MHSA PEI legislation reporting requirements focus on individual demographics, referrals to treatment, and individual outcomes. To meet this requirement, an independent evaluation consultant, RDA Consulting, provided planning and technical assistance to San Mateo County PEI. Twelve (12) PEI programs provide some component of individual-level services. Through a series of meetings with PEI program staff to develop an understanding of the PEI programs, current data collection, and explore the feasibility of standardized indicators and new data collection tools, RDA Consulting 1) mapped out the PEI requirements to each program; 2) developed a standardized reporting template; 3) developed unique program crosswalks to utilization of the reporting template; and 4) developed a PEI Data Collection and Reporting Framework, see Appendix 7.

PEI programs that primarily provide community awareness, outreach and referrals and system-change services aren't able to collect unduplicated individual-level data and were not included in this first round of the PEI Reporting Framework. Future efforts will look into how to integrate broader systemic and community impacts to meet local San Mateo County goals for upstream tertiary prevention services.

The PEI Reporting Framework aimed to **identify PEI data and individual outcomes** that could be analyzed across all PEI programs to demonstrate the collective impact of PEI. The data will feed into the required MHSA Three-Year PEI Evaluation Report. The next PEI Three-Year Evaluation Report will cover FYs 2020-21 to 2022-23, and will be due June 30, 2024.

To allow for BHRS to assess this collective impact, a set of Outcome Domains were introduced under which programs can report their specific data. These Outcome Domains were identified to be in alignment with MHSA requirements, the BHRS Office of Diversity and Equity's (ODE) Theory of Change, and through PEI program staff input regarding their unique expected outcomes. The **PEI Outcome Domains** used in this framework include:

1. Access to services
2. Community advocacy
3. Connection and support
4. Cultural identity /cultural humility
5. General mental health
6. Improved knowledge, skills, and/or abilities
7. Self-empowerment
8. Stigma reduction
9. Utilization of emergency services

New data collection now includes individual clients served (unduplicated); individuals reached (duplicated); demographics; referrals; and individual outcomes under the PEI Outcome Domains.

PEI AGES 0-25

The following programs serve children and youth ages 0-25 exclusively and some combine both Prevention and Early Intervention strategies. MHSA guidelines require is 19% of the MHSA budget to fund PEI and 51% of PEI budget to fund program for children and youth.

EARLY CHILDHOOD COMMUNITY TEAM (ECCT)

The Early Childhood Community Team (ECCT) aims to provide targeted, appropriate, timely responses to the needs of underserved families with children ages 0 through 5 or pregnant mothers in the Half Moon Bay community. ECCT focuses on the parent/child relationship as the primary means for intervention. Team members also focus on child development and strive to individualize services to ensure each child and family's unique needs are met. Identifying challenges early and providing families with the proper assessments, interventions and supports can make a difference in a child's earliest years and for many years thereafter. ECCT is made up of three interconnected roles that support the community and families in different ways.

1. The Community Worker (CW) provides case management and parent education to the families, facilitates play groups and support groups, and develops and maintains partnerships in Half Moon Bay community.
2. The Mental Health Clinician (MHC) provides Child Parent Psychotherapy (CPP) informed therapeutic support to families as well as using other attachment/relationship based clinical modalities as appropriate. CPP is a specific intervention model for children aged 0-5 who have experienced at least one traumatic event and/or are experiencing challenges related to attachment, and/or behavioral problems, including posttraumatic stress disorder. The primary goal of CPP is to support and strengthen the relationship between a child and his/her caregiver as a vehicle for restoring the child's cognitive, behavioral, and social functioning.
3. The Early Childhood Mental Health Consultants (ECMHC) provide ongoing support to childcare providers in preschool settings with the goal of establishing a safe and trusting relationship that supports teachers in building their capacity of self-reflection, understanding of the child's experience and fostering an inclusive classroom where all children can receive high quality care. Consultation services also provide more intensive case support for children who have been identified with significant needs or who are at risk of losing placement at their site. For this more intensive work, ongoing support is provided for parents in hopes of bridging the child's home and school experience and creating a feeling of continuity of care.

Program Impact

Early Childhood Community Team*	FY 2021-22
Clients served (unduplicated)	62
Cost per client	$7,137
Individuals reached (duplicated)	150
Total Served	212

** Unduplicated clients served are the children/families that participated in individual or group therapy, individuals reached includes parent/caregiver groups, teacher consultations, etc.*

Outcome Indicators

Domain	Indicators/Questions	#	%
Connection & Support	Number of parents/caregivers who improved familial connection and support as measured by improvement in Protective Factors Survey Score Due to engagement in this program, I feel more connected with other parents and have learned more about resources in my community (1:1 services and group)	4 of 5	80%
Improved knowledge, skills, and/or abilities	Due to my engagement in this program, I feel more confident in my parenting (group services) How effective was the consultant in increasing your understanding if your child's needs? (ECMHC)	4 of 5 No data	100%
Connection & Support	Due to my engagement in this program, I feel more connected to other parents in my community (group)	4 of 4	100%
Stigma Reduction	I feel more comfortable talking about my and my child's mental health/ children in my classroom (population: group, teacher consultations, and one-on-one services) How effective was the consultant in contributing to your understanding of the family's situation and its effects on the child's current behaviors? I feel more comfortable seeking out resources for myself and/or my child	5 of 5 5 5 of 5	100% 73% 100%

Knowledge/ access to services	Due to my engagement, I know where to go in my community for resources and support. (population = groups, teacher consultations, and one-on-one services)	4 of 5	80%
Community Advocacy	Due to my engagement, I feel more empowered to advocate for myself and my child's needs. (population = group and 1:1)	5 of 5	100%
Cultural Identity/ Humility	I feel like my identity is affirmed by this program. (population = groups, teacher consultations, one-on-one services)	5 of 5	100%

*****The development and implementation of the PEI Reporting Frameworks occurred late in the reporting period, so the data is not representative of the full reporting period.

Demographics

Total Children	Male	Female	0-5	Ethnicity	Language
64	31	33	64	2 Asian	20 English
				10 Caucasian	24 Spanish
				52 Latinx	

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals		5	5
Substance Use Disorders (SUD) Referrals	1		1
Other Mental Health (MH) Referrals	8	12	20
TOTAL	9	17	26

Referrals to Other Services

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	1	Legal	1
Financial/ Employment	6	Medical care	0
Food	4	Transportation	0
Form assistance	5	Health Insurance	0
Housing/ Shelter	10	Cultural, non-traditional care	1
Other	3	**TOTAL**	**31**

Program Narrative

Mental Health Counselors FIRST! Weekly Child-Parent Psychotherapy was provided to 12 children (and 13 caregivers) in the Half Moon Bay community. Weekly services include child/parent therapy, family therapy, collateral individual sessions with caregivers and additional collateral contacts such as school observations, participation in Individualized Educational Plan (IEP) meetings, etc. Most participants receive psychotherapy services for at least one year.

The Community Worker provided support and services to 13 children (and 13 caregivers), which includes case management, providing activities supporting the caregiver/child relationship and child's development, parent education and assessment. Of the children and caregivers, 7 families are working with both the Community Worker and Dyadic Therapist. An additional 16 children (and 16 caregivers) participated in the in-person Parent-Child Activity group held in the Spring at the Half Moon Bay Library. Three caregivers in the community contacted the Community Worker directly looking for supports, the families were supported in referrals for appropriate services in the community. In attempt to reach more caregivers to share parenting resources and information, outreach was done in the Half Moon Bay community for 2 Facebook Live events where ECCT was represented by the Half Moon Bay Community Worker and Assistant Director on the panel. This Facebook Live event engaged 57 caregivers. Since the events, they have been shared and viewed hundreds of times! No system has been set up regarding the Facebook Live events to be able to track what specific communities' caregivers are from, however it is important to highlight the success of reaching additional caregivers with important information and themes in this way.

Mental health consultation services were provided to 3 childcare programs in the Coastside region serving 64 children and 19 staff. It is important to note that just like last year, program numbers differ greatly from previous year due to low enrollment due to the Pandemic. It is also important to mention that due to staffing shortage, there were no services at two sites this year; Moonridge Head

Start and Moonridge Early Head Start. Due to the reduced slots as well as a lower number of sites served, numbers for more intensive consultation services were also impacted. This year consultants, provided 10 “Light Touch” services (10 parents), which are services provided to identified families with more specific needs that vary in intensity and for which the consultant can meet for 1- 5 session to provide support as well as any referrals if necessary. Consultants also provided serviced to 5 children who were identified by teachers as benefitting from more intensive “Case Consultation” services. The program also facilitated 9 workshops to parents on topics ranging from Child development, Inclusion, Transition to Kindergarten and The Power of Relationship. Consultation activities include individual and group mental health consultation meetings with childcare providers and site supervisors, individual meetings with parents, parent workshops, observations of classrooms and individual children as well as assistance with resources and referrals if/when needed. Consultation was provided through tele-health for the entire school year due to COVID-19 restrictions. Virtual meetings were held on a weekly or monthly basis in group and individual meetings depending on the specific needs and availability of each center and staff members. Meetings with parents also were delivered via tele-health or phone.

Ongoing communication and collaboration between the ECCT team members occur regularly to assure that each family’s needs are known, addressed and supported by the team members working with each family. This is one of the main components of the ECCT program and one that distinguishes us from other programs in the community. Mental Health Consultants, Mental Health Clinicians and Community Worker all meet as a team twice per month at a minimum to ensure collaboration of shared cases as well as a space where clients are “held” and teams can brainstorm together on best practices, possible referrals and how to continue to provide attuned and “in depth” care.

Improves Timely Access and Linkages for underserved populations:

One of the goals of ECCT is to keep existing partners and ECCT families aware of how to make new referrals, the schedule of upcoming groups, and new resources, as well as being strategic to reach new families within the communities served. This fiscal year the Intake Coordinator has worked closely with another Early Childhood Services Program to stay up to date regarding groups offered for caregivers via telehealth. Offering a variety of groups open to caregivers at Intake has allowed parents to connect with parent support groups offered at various times. The Intake Coordinator, Mental Health Clinician, Mental Health Consultants, and Community Worker are primarily bilingual in Spanish and English. Staff is required to complete eight annual hours of diversity training to integrate a more culturally responsive approach to their work. In addition to outreach efforts, families often self-refer after hearing about supports and services from other families that have worked with ECCT themselves. Referrals also come from schools, community partners, and internal referrals within Star Vista. Once a referral is received, the Intake Coordinator connects with the caregivers within two-three business days and completes a detailed phone Intake. The phone Intake involves listening to caregivers' immediate concerns, gathering information on what supports/services they are interested in, and what risk factors are known. Depending on what the caregiver shares, the family may be

referred right away to community resources outside of ECCT in addition to being connected with either the appropriate Community Worker and/or the Mental Health Clinician so that either of them can begin their work with the family immediately. For any families on the Wait List, the Intake Coordinator follows up with them regularly to check in, assess for any changes in needs, and provide any new information on available groups and/or resources that may be relevant to their needs.

Beginning at Intake, staff of ECCT meet caregivers where they are in terms of how they feel about the referral being made and what their level of comfort with engaging in services might be. Families are encouraged to talk about what worries or hesitations they might have in engaging in services, which sometimes includes caregivers sharing negative experiences they have had in seeking support in the past as well as stigma around mental health within their own culture and/or family. ECCT staff are thoughtful and intentional to provide a safe space for families to explore any hesitations to connecting with ECCT services. ECCT staff work within this trusted relationship to support families in connecting with various public health services core agencies as well as other programs within the community as appropriate and as caregivers are ready.

Remaining connected within the community and being available for 1:1 introductions and answering questions is a foundation of the success of ECCT. In effort to decrease the stigma around mental health, ECCT staff continue to attend events in the community, which provides the opportunity to begin and build relationships as well as connect with families about ECCT services. Community partnerships are an integral part of the ECCT model so the team feels part of the community and is aligned with what is happening specific to the area. Part of the goal within ECCT is to support and empower caregivers to be aware of, and able to, access resources within their community, a piece which will last long after their work with ECCT services end.

Mental Health Consultants are ready to support children who have been identified by teaching staff as needing more intensive services due to behavior, social emotional and/or developmental concerns. Sites that have regular access to a consultant can very quickly connect a family with them and ensure timely linkages to services that support not just the child but also the family. Ongoing Mental Health consultation support allows for constant communication about children in the classroom and families served in the program, especially those that are demonstrating emotional needs and/or behaviors that might require more attention. At some sites, teachers have been able to identify children even before they start at the program through Ages & Stages Questionnaires (ASQ) screening done at enrollment which they can use as an opportunity to discuss consultation services with parents and get child connected even prior to him staring at the school. This allows for early identification and timely referrals that ensure that child receives the support they need to thrive in the classroom. In other circumstances, a child that has been identified by through staff in the classroom setting, they are able to check in with parents around bringing in a consultant to support them in better understanding the child within the context of the classroom. When the parent has consented, consultants can then begin the conducting classroom observations of the child as well as meet with teachers and parents to get more information in order to paint a better picture of what

may be happening for the child. It is through this deeper understanding that consultant, teacher and parent can develop implement more attuned strategies at home and school that will in turn support the social-emotional development of the child. Through this process, teachers and families come together and work hand in hand in completing assessment tools that paint a richer and broader picture of what is happening at home and school. If necessary, children are also referred to further assessments and/or services that target their specific developmental needs. Consultants also link identified families with services through Light Tough consultation services. If a family has been identified, or has on their own requested additional support, consultants are there to support them in linkages to community resources. This year, families were referred to special education services within the school district, mental health services for additional members of the family, housing, Domestic Violence support and Legal Aid Services.

The constant presence of a Mental Health Consultant on site as a familiar face for parents within the community has proven, over the years, to be an effective way for parents to be willing to connect with a consultant for Mental Health Services. This has been found this to be true, for parents who are accessing services for the first time as well as for those who have not had a positive experience with mental health services in the past. For many families, the Preschool is a safe and trusted place thanks to the relationships they form with staff, this makes parents much more willing to sit with a Mental Health Consultant when the service is being offered by a trusted teacher of family support staff. The "Light Touch" services often lead to parents being connected to more comprehensive services including community resources or mental health support for themselves or someone within the family systems. This flexible approach allows us to "sit" with parents for several sessions and assess what their needs thoughtfully and with intention while at the same time prepare them for the possibility of therapy or other service that may be valuable. Possible barriers of accessing services were explored and there was an attempt to find ways to break through them. Once services are accessed, the unique model allows for a warm handoff to the Clinician which highly increases the likelihood of parents being more committed and engaged with the Clinician from start of treatment. This is also true when parents are referred out for their own individual therapy with partnering agencies. Consultants are for many, the first point of contact and one that "meets clients where they are at" allowing them the space and taking the time for them to be ready to connect with more intensive services. In the same way, Consultants, which all are trained clinicians can "hold" the family using a therapeutic approach while they are on any waitlist for services. Once they are linked the Consultants have the opportunity to continue working with the clients within the school and also collaborate closely with Clinicians, Community Workers, Early Intervention supports, Social Workers or any other provider that works with the family.

Reducing disparities in access to care and implementing recovery principles

At the core of the work within ECCT is the relationship staff have with family members. Treating the family with respect, with cultural humility and within the family's preferred language are important. Central to the work is the belief that the relationship between ECCT staff and caregivers is parallel to

the relationship between child and caregiver. Beginning at Intake the intent is to gather information from the caregivers and allow their input to guide the services, treatment goals and pace of the work using strength-based language. Meeting caregivers where they are at and truly allowing their family's needs, concerns, culture and beliefs to drive the work is at the heart of the ECCT program. For this to occur, communication and respect is key. ECCT staff work focuses on remaining curious with families and allow the work to follow the needs of the family, not the determination of the ECCT staff. At regular points throughout the work, within all the roles of ECCT, there is time set aside to reflect on the work, progress and challenges. This allows the opportunity to evaluate the caregiver experience and make any adjustments as needed. Being placed in the community is also essential since it provides staff with a deeper understanding of the community and the needs. To understand the resources, trends, and challenges that families encounter daily allows ECCT staff to have a more holistic approach in the work and provide support in a way that feels responsive to the client and to the community. Many families, due to the ongoing political climate, have remained hesitant to connect with some services due to fear of deportation or fear that accessing services, even emergency COVID-19 relief programs, may impact the family's eligibility to apply for a green card. The Community Worker has made herself available to support families with any appointments they were concerned about to help relieve some of the anxiety the families were going through.

Core tenets of Flexibility and Commitment to understand multiple perspectives, allows for the unique tailoring of services for not just the clients ECCT serves but for the larger systems consulted to. Consultants are constantly checking in with sites to ensure that their needs are being met effectively and to make any necessary adjustments that are needed to ensure that childcare staff as well as the families enrolled are receiving the most attuned and responsive care possible. Consistent Mental Health staff meetings, which occur at least monthly but ideally weekly, are a way of ensuring constant communication with staff about their own needs as well as the needs of the children and families they serve. It is important to note that the culturally sensitive and social justice-oriented framework is one that allows for discussion on issues such as disparity, inequity, systemic oppression, community violence and immigration trauma safely brought to consultation spaces so that healing can occur. Consultants and clients think together about language barriers, cultural differences and how these issues impact the caregiver's connection to the child and families as well as how their own trauma might impact those relationships. Within the context of a safe and trusting relationship with the consultant, teachers can explore their implicit biases and how they inform their understanding of a child and of a family's experience. ECCT strongly believes that only in addressing and understanding these deeper issues teachers can build solid connection with children and families through increasing empathy and therefore developing more responsive interventions and strategies. Through this, the hope is that teachers become aware of their unconscious assumptions and have a better understanding of how they play out in their classroom and impact all the children under their care. The hope is that this creates more inclusive and sensitive teaching in the classroom.

For the past two years there has had to be even more intentionality in ensuring that Mental Health Consultation services are uniquely tailored to the needs of the programs due to the COVID-19 pandemic. Through consistent checking in with sites, Consultants were able to constantly learn about COVID policy updates that impacted the staff and the families served. These policies changed often and very quickly which meant that the delivery of services needed to constantly be adapted and tailored to the site. No two sites functioned in the same way, even within programs in the same larger agency. The consultants and ECMHC Manager met often with site supervisors, Directors and agency administrators to get as much information as possible about the functioning of the sites and attempt to make the delivery of services as attuned as possible. This proved to be quite a challenge as often times it meant not being able to visit sites regularly. Having regular mental health staff meetings are a way of ensuring constant communication with staff about their own needs as well as the needs of the children and families they serve. The past two years have been filled with uncertainty, challenges, fears and anxiety as well as chronic stress for many teachers. Teachers continued to report high levels of stress, burnout and fatigue due to issues such as illness, short staffing, children displaying higher than normal separation anxiety and social emotional delays. Therefore, the consultation space was especially important for them to be able to express and work through their complex feelings. The consultation framework believes that in teachers being able to share their experiences and having a trusted mental health professional "hold" their experience with them, they are better able to "show up" for the children and families in their care. For many teachers, the therapeutic space that is offered in consultation, is the main place where they can check in around their mental health. Through the attachment lens, needs of the caregiver are met so that in turn, they can show up for the children under their care and better able to meet their needs.

Consultation services also supported children displaying challenging behaviors, reducing their risk of suspension and expulsion and supporting the school's capacity to sustain these children in their programs. Out of the 5 cases that were opened for intensive case consultation services, none were expelled or suspended. Consultants and teachers often use the consultation meetings to think together about the meaning behind behaviors and try and get a better understanding of the child's needs. This approach allows for a much more attuned response to behaviors that is aligned with the need the child might be expressing. Thanks to the consistent meeting space offered by the consultant, teachers can follow up and reflect on which type of intervention works and which need to be shifted, modified or changed completely. Finding what "works" takes multiple tries and tremendous effort on the part of the teaching staff. One of the main ways that consultants support teachers in these efforts is by visiting the classroom and conducting observations in order to "bear witness" to the teachers' classroom experiences. Consultants then offer a reflective space where teachers can share what was happening and their own personal experiences, the challenges and the successes. Through a reflective approach, teachers are invited to develop an awareness of their own experience in a particular moment, and this be more grounded and intentional in their work. Teachers that can be self-aware and intentional report feeling more regulated and better able to seek out support when needed. Consultants provide encouragement and guidance to teachers while

holding onto the hope for change that considering the overwhelming work, they manage teachers may not be able to hold onto themselves.

Lastly, one of the most effective components of the program is to work with community partners to identify gaps in families having access to services. The ECCT team makes efforts to connect families with programs that could provide ongoing support for families or in some cases that gap is filled short term by the ECCT team. Having regular conversations as providers with other community providers allows for consideration and coordinated attempts to work towards filling identified gaps and establishing a commitment to continuing to address needs and challenges as they arise. The Community Worker maintains strong relationships within the community with both community members as well as community providers. These relationships have been crucial to getting families connected with much needed services.

Successes

Client Story: This family success story involves a Mental Health Clinician, Community Worker and Mental Health Consultant collaborating to support the family. Mother was initially referred by her Ob-gyn physician when pregnant with client. Mother was initially hesitant to begin mental health services and was connected with the team's Community Worker to support her in her numerous case management needs and meet Mother where she was at. Mother has a complex history of trauma of her own, a history of Post-Partum Depression with her previous pregnancies and there was no family support at the time of the referral. The Community Worker provided referrals and assistance bridging Mother to community resources and supports as needed. Over time, during the process of this work with Mother, the Community Worker worked on building trust and providing support and providing information to help Mother consider, and eventually be ready for, beginning work with a Mental Health Clinician on the Early Childhood Community Team.

Mother began working with the Mental Health Clinician and was regularly engaged in services with both the Community Worker and Mental Health Clinician to meet treatment goals to support/strengthen the mother-child relationship. Around time of pandemic Mother was so overwhelmed by loss of employment, loss of family members to COVID-19 and other related stressors, that her engagement in services became inconsistent. Team members continued to reach out, remind her that they were available when she was ready to meet, and this supportive patience was successful in that mother reengaged in services as she felt more ready to. Unfortunately, during this time of inconsistency in services, there was an unfortunate traumatic event experienced by the family. There was Police and Child Protective Services (CPS) involvement, and the ECCT staff supported Mother in their meetings with her and connecting with CPS Worker as needed. This recent trauma became the focus in the dyadic therapy with the Mental Health Clinician at the same time child began attending a center-based daycare/preschool setting. Due to the trauma event, child began displaying challenging behaviors in the classroom and teachers began sharing their concerns

and classroom challenges with the Mental Health Consultant on-site. The Mental Health Consultant reached out to the Community Worker and Mental Health Clinician and with family consent, was able to collaborate and begin planning to support family and center-based caregivers, as well as child's experiences across environments.

At this time, child's behaviors escalated to the point that teachers and center-based staff were calling Mother on a regular basis to pick child up early due to behavioral incidents. School staff began discussing that the child may not be a good fit for their program and the possibility that child could potentially be asked to leave. The Mental Health Consultant was able to begin meeting with teachers and administrative staff to explore more about the behaviors observed, their experiences with both mother and child, and provide some context (in general and based on Mother's consent) regarding the family's experience and behaviors related to child's trauma history. The Mental Health Consultant, Dyadic Therapist, Community Worker, preschool staff and Mother were able to meet to discuss child, his needs and plan together to support him within the context of his current classroom. Teachers were able to rearrange some things in the classroom environment to support child and were able to explore together what was working/not working with him as they tried different interventions and supports in the classroom. Teachers built capacity that led to closer relationships with child as well as with Mother, and over time there has been a significant decrease in challenging behaviors in the classroom. Within the context of Dyadic Therapy, both Mother and child worked on their language and communication in identifying feelings stemming from their recent trauma incident, asking trusted adults for help, building self-regulation skills as well as Mother learning skills to help co-regulate child when they are together.

Throughout their work together, the Community Worker has supported Mother in connecting with various resources in the community as needed. Referrals made have included: Legal Aide, Ayudando Latinos a Sonãr (ALAS), housing referrals as well as Coastside Hope. The family has experienced financial and housing instability, which was made worse during the pandemic. The Community Worker has worked with Mother to empower her, to be aware of community resources and to be able to make these calls and connections on her own as she has built confidence.

Teachers are no longer worried about child in the classroom and feel confident in the progress made. Unfortunately, the family has recently experienced another traumatic event in their lives, and with the established relationships and work that has already taken place to support mother and child, it is hopeful that they will continue to build on what they have learned and be more empowered to navigate the systems and supports in their community when they close with their current team.

Another 'success' change for ECCT this reporting period is that new office space has been acquired as part of the new Community Hub space on Cunha Middle School campus. ECCT staff are excited to be part of this new space with valued Community Partners. The new Community Hub office will allow for an inviting, comfortable, private space for individual meetings, groups and family meetings. This upcoming new space is exciting for the team and families!

Challenges

Challenges this reporting period included, of course, the continued impact of the COVID-19 pandemic on the families in the community. Families continue to struggle with ongoing impact of the pandemic in the areas of housing, financial and food instabilities. Challenges this year have included inability to pay rent due to employment changes and limited housing resources in the community in comparison to the level of families in need. Families have experienced challenges in attaining needed resources due to documentation requirements for aid. Families have also struggled to connect with new supports due to their level of stress and ongoing needs. Living within the small community there is sometimes a hesitancy to receive supports in the community, for fear of the stigma around receiving mental health and/or other related services. The majority of services have continued to be via telehealth platforms this reporting period. ECCT staff are working with each family to assess and plan for in person meetings to feel safe and appropriate. Dyadic work via telehealth platforms has proven challenging with this age group despite efforts of Clinicians to offer engaging and interactive activities for sessions. The team anticipates more consistent engagement and availability of caregivers as the fear and impact of COVID-19 lessens, and as meeting in person in the new office space feels safer and more comfortable.

A separate impact on the work during the COVID-19 pandemic has been related to ECCT staff. ECCT has continued to experience being short-staffed during this reporting period. There has been restructuring of the Team and Department to work towards retaining staff, and while new staff have been newly hired, open positions remain.

An ongoing challenge continues to be available resources for those who age out of the ECCT program. There have been significant challenges within the communities of Half Moon Bay and La Honda/Pescadero in terms of programs available for continued mental health and case management support post- ECCT. Assisting families in transferring to Coastside Mental Health, Puente and School based services have been challenging at times. ECCT has provided extended services for some families as necessary and the team is able, however this is not always possible.

Despite the increase in needs for families already connected with ECCT services, there have been fewer referrals to the program overall this fiscal year, especially for families within Half Moon Bay. Efforts to provide group spaces for caregivers in Half Moon Bay virtually were a challenge this year as well. There was one group series and one workshop organized and no parents participated. A significant reason for lower referrals is ECCT not being fully staffed as well as not being able to be physically onsite at preschools this fiscal year. Mental Health Consultants are typically a consistent referral source for the ECCT program. With the reopening of public spaces, ECCT has participated in local outreach efforts in the community, participate regularly in the monthly Coastside Collaborative meetings, as well beginning to co-facilitate play groups in person at the Half Moon Bay Library. These efforts, in addition to Mental Health Consultants building to full capacity and physically returning to preschool sites this fall, will hopefully lead to returning to regular referral numbers and ultimately

connecting with more families in the community. The Parent-child Activity groups returning to in-person have resulted in consistent attendance by families, which the team anticipates will continue.

An additional challenge has been the collection of data- surveys- for feedback from caregivers. Efforts are being made to ensure regular, consistent data collection to be able to report on all areas below at the end of individual services as well as groups. Surveys have been developed; however, collection of these surveys has been challenging due to caregiver follow up at the end of services/groups. The process for collecting the data has been to send it separately to caregivers for them to fill out and submit/return. An online survey link (available in English and Spanish) was developed to make it easier for caregivers to complete and submit, while a paper copy or phone call are also offered as options for caregivers to complete the surveys. The intention moving forward is to allow time during the last group or session for the caregiver to ensure completion of the survey, as well as to provide any support needed in case there are any questions or challenges that the ECCT staff can assist with. The ECMHC program also was not able to get any of the parent surveys back from parents who they were sent to 15 parents (6 case consultation services and 10 Light Touch Services). Teacher surveys were also lower than usual this year as only 5 were received back from the staff who received services this year. The hope is that being at sites in person this coming school year will highly increase data collection as consultants will be able to get them back on the same day they provide to staff.

The consultation work has faced significant external and internal challenges this year. For the past two years there has been a great impact from the COVID-19 pandemic. Policies and safety procedures contribute to make it difficult for the us to provide services in ways that align with the ECCT model. Not being able to be physically present at sites has interfered with continuity of care, the ability to be witness what happens in the classroom and also the follow up that happened very organically when consultants visited the site weekly. For some sites, ECCT is able to come at limited capacity for very short child observations only. Staff meetings happen only once a month at times and staff shortages often mean having to cancel meetings due to lack of coverage. Teachers have felt this deeply, as evidenced by the staff satisfaction surveys that show teachers rating services lower this year. Most of the comments include feeling frustrated that consultant do not show up regularly, not being able to follow up quickly with consultants after they conduct a child observation or not having time to connect with consultants via email or phone which makes it harder for them to refer children.

Schools continue to have low enrollment, sometimes at less than half capacity which greatly decreases number of children reached by the program. This year, classrooms were expected to return to full capacity, but numbers continue to be low. Programs have reported enrollment has been challenging due to some parents still being fearful of sending children back to school in person, the expectation is to see an increase of children at the sites. Less children reduced the number of both children and staff served. It also decreased numbers of case consultation services and “light touch” services. Since consultants were not yet allowed on site physically consistently, it was left up to staff to connect us with families that expressed interest in services and/or were identified as having a need by school staff (who also struggled to refer families for various reasons). Many parents refused the

referral for consultation services due to not feeling their child needed “mental health support”. It is believed that the inability to be present as a “friendly face” on site and build connections with parents was a barrier. This confirms what was known about the program’s “stance” and approach; for many families, the school is a safe and trusted place, which makes parents much more willing to sit with a Mental Health Consultant when the service is being offered by the trusted teacher to a familiar face that parents see every week in site.

Referrals were also impacted due to teachers continuing to report extremely high levels of stress, fatigue, and burnout that are still connected to this “new normal”. Fears of getting sick with new variants, the loosening of safety guidelines, constant classroom closures, staff shortages in every classroom, on top of their many duties and responsibilities caring for young children contributed to teachers struggling to think more deeply about children’s behaviors. Teachers continued to use the consultation space was one where they shared and reflected on their experience and sought the emotional support for themselves. Though this is an integral part of the consultation work, this year, this part of the work took precedent over the slowing down and thinking about what is happening for children in the classroom. What has been learned during this pandemic is that when a caregiver is in a state of crisis and survival mode their capacity to think more deeply about the meaning of behaviors is impacted. Many conversations with teachers are centered around their own mental health and their ability to show up in the classroom every day for the children and families they serve.

As a program there has been internal challenges as well. The team lost 5 members from July-December which greatly affected capacity to provide services to the centers. Though there was the ability to find coverage for most sites, thanks to all remaining team members taking on extra work, there were two of the sites served through this funding that were not served. Moonridge Head Start and Early Head start were on an on-call basis only which meant that staff was not able to reach any children or teachers at those sites. The Department Director, who had been an integral part of the team for many years, also left the agency in December. The program manager stepped down in June. These changes have great affected staff morale and workload. As of now, the ECMHC program has a new manager, and the department has a new Director as well. There have been two new staff hired, one of which will be taking on Moonridge Head Start and Early Head Start.

COMMUNITY INTERVENTIONS FOR SCHOOL AGE AND TAY

PROJECT SUCCESS

Project SUCCESS, Schools Using Coordinated Community Efforts to Strengthen Students, is a research-based program that uses interventions that are effective in reducing risk factors and enhancing

protective measures. Project SUCCESS is a SAMHSA model program that prevents and reduces substance use and misuse and associated behavioral problems among high risk youth ages 9-18.

Project SUCCESS is designed for use with youth ages 9-18 and includes parents as collaborative partners in prevention through parent education programs. Clinical staff trained in culturally competent practices ran all the groups. All of Puente's Behavioral Health and Recovery Services (BHRS) staff are either licensed or pre-licensed by the Board of Behavioral Sciences (BBS). Project SUCCESS groups are offered to all three school campuses in the La Honda-Pescadero Unified School District (LHPUSD). The school district's small size provides an opportunity for every student in the district, ages 9 to18, to participate in one or more Project SUCCESS activities.

Each academic school year, a passive consent letter explaining Project SUCCESS curriculum is sent to all parents with children ages 9 to 18. There is an opportunity for parents to have their child opt out with a signature at the bottom of the consent letter. Project SUCCESS activities include:

1. Social Emotional Learning
2. Psychoeducation workshops with students, parents, and community members
3. Individual and family counseling services
4. Parent and Teacher consultation
5. Mental health community awareness and education

Program Impact

Project SUCCESS	FY 2021-22
Clients served (unduplicated)*	154
Cost per client	$1,986
Individuals reached (duplicated)	217
Total Served	371

** Unduplicated clients served are the students that participated in the intervention and individual and family therapy, individuals reached includes parent/teacher consultations, and community awareness and education.*

Outcome Indicators

Puente is unable to report on general mental health outcomes for the individual and group therapy participants. Puente's Community Mental Health and Wellness (CMHW) clinicians were inconsistent in their collection of depression and general anxiety screeners Patient Health Questionnaire-9 (PHQ-9) and General Anxiety Disorder-7 (GAD-7) throughout the year and the metric was finalized in the spring of 2022. Staff will receive an overview training of these assessments in the fall and plan for data collection, so that clinicians can begin to collect this data at a point during the first half of the year and near the end of FY 2022-23.

Domain	Indicators/Questions	#	%
Self-Empowerment	I learned about myself and my thoughts and feelings in this program (5th graders, n=15)	4	36%
	I learned about myself and my thoughts and feelings in this program (8th graders, n=19)	5	26%
	Being in this program helped me understand how to better manage how I respond to my thoughts and feelings (5th graders, n=15)	4	36%
	Being in this program helped me understand how to better manage how I respond to my thoughts and feelings (8th graders, n=19)	9	47%
Improved knowledge, skills, and/or abilities	Because I was in this program, I learned skills that help me express my emotions and opinions more effectively (5th graders, n=15)	4	27%
	Because I was in this program, I learned skills that help me express my emotions and opinions more effectively (8th graders, n=19)	6	32%
Stigma Reduction	Because I was in this program, I feel more comfortable talking about challenges with using alcohol and/ or drugs (5th graders, n=15)	5	33%
	Because I was in this program, I feel more comfortable talking about challenges with using alcohol and/ or drugs (8th graders, n=19)	4	21%

*****The development and implementation of the PEI Reporting Frameworks occurred late in the reporting period, so the data is not representative of the full reporting period.

Demographics

Puente was not able to collect information for demographics due to staff shortages at the time the data template was finalized. The Clinical Director will be working with the Program Associate and CMHW clinicians to ensure that all demographic data will be collected on an ongoing basis through next reporting period.

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals			
Substance Use Disorders (SUD) Referrals			
Other Mental Health (MH) Referrals		1	1
TOTAL		1	1

Referrals to Other Services

Puente was not able to collect information for the Social Determinants of Health Screener, which would bolster referrals to other services, due to staff shortages at the time the data template was finalized. The Clinical Director will be working with the Program Associate and CMHW clinicians to ensure that all demographic data will be collected on an ongoing basis through next reporting period.

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services		Legal	1
Financial/ Employment	3	Medical care	1
Food	5	Transportation	0
Form assistance	2	Health Insurance	0
Housing/ Shelter	1	Cultural, non-traditional care	0
Other	0	**TOTAL**	**12**

Program Narrative

For FY 2021-22, primary program activities included delivering the Project SUCCESS prevention and early intervention curriculum to 29 5th graders and 28 8th graders (all students in the La Honda-Pescadero Unified School District); individual and family counseling services; parent and teacher consultation; and mental health community awareness and education. The 5th grade classrooms received 8 lessons of Project SUCCESS and the 8th grade classroom received 6 lessons of Project SUCCESS. Other primary activities provided through Project SUCCESS include:

- Individual and family counseling services: CMHW clinicians provided therapy to 97 unique individuals, ages 5-79. Most participants met with their therapists weekly and 85% of

participants were connected to the LHPUSD community in some way (students, parents/ guardians and extended family members of children enrolled, and school staff and administrators). CMHW clinicians also provided case management for participants, on an as-needed basis, supporting connections through referrals for Medicare/Medi-Cal coverage, medical and dental procedures, educational assessments, and other social services.

- Parent and teacher consultation: CMHW clinicians provided approximately 12-20 consultations per month to parents/ guardians and school staff during the school year.
- Mental health community awareness and education: CMHW clinicians initiated a psychoeducational series designed to address the ongoing effects of COVID-19, called *Pandemic Stress, Fatigue, and Trauma: Healthy Practices for Uncertain Times*. This 2-part workshop was initially offered to Puente staff (as a start to an ongoing monthly *Transforming Trauma and Stress* series for Puente staff), with the aim of continuing to provide these sessions to the community through the next fiscal year. In May and June 2022, 28 Puente staff participated.

Improves timely access and linkages for underserved populations

Puente's service region is home to San Mateo County's most underserved population. Participants from Pescadero, La Honda, San Gregorio, and Loma Mar, face numerous challenges to accessing health care including mental health care. South Coast residents with low socioeconomic levels are more likely than higher-level groups to have access issues, including the absence of health insurance and inadequate transportation to medical/health appointments. Moreover, individuals who do not receive health insurance subsidies, such as undocumented immigrants, often lack the means to pay for health care. In addition to working physically demanding low-wage jobs, many participants are non-English speaking immigrants who have experienced multiple stressors and trauma. As was mentioned, nearly all community members have been impacted by the ongoing pandemic stress, fatigue, and trauma, as well as the devasting San Mateo-Santa Cruz (CZU) fires from 2020. Due to this, Puente's mental health and wellness services began a shift to addressing these issues on a universal level, knowing that everyone has been impacted.

All students and their families (ages 9-18) in the school district have access to Project SUCCESS and the Trauma-Informed Services for Youth' Mindfulness-Based Substance Abuse Treatment (MBSAT) program. Depending on staffing levels, every youth, family member, and school staff member have complete access to consultation, as well as a direct referral to therapy, and treatment with a trained mental health clinician at Puente, at the beginning of FY 2021-22, staffing included a part-time (.2 Full-Time Employee – FTE) interim clinical director, one part-time (.8 FTE) staff clinician, two full-time (2 FTE) clinicians, and three part-time (.5 FTE total) contractor therapists. Just before the new Clinical Director started in September, two full-time clinicians left. One took a different job over the hill and the other relocated to a different state. CMHW clinicians continued to provide therapy services to existing participants and newly referred participants were placed on a waiting list until a new clinician

started. By offering free mental health care to residents in the service area, Puente is ensuring that vulnerable community members have access to the mental health services that they need.

Therapy services were primarily accessed via telehealth over FY 2021-22 due to the ongoing COVID-19 pandemic (Project SUCCESS programming was offered in-person across all three schools in the spring of 2022). Puente's clinical team was creative in their approach in connecting with participants by making multiple attempts through various communication strategies including text, WhatsApp, email, and voicemail. Still, the online nature of services may have hindered some access for individuals who felt uncomfortable with the new technology initially, though when the team resumed in-person services in spring of 2022, most participants wanted to continue with telehealth. Participants who wished to be seen in-person resumed therapy in one of Puente's offices or on a school campus.

Reduces stigma and discrimination

Project SUCCESS are opportunities for students ages 9 to 18, and their families to engage with trained mental health clinicians in an educational format, workshop format, and therapeutic sessions to build relationships that break down the stigma of mental health and substance use issues and reduce the stigma for seeking treatment. Puente's CMHW team promotes mental health awareness, provides education in accessible formats, and makes access to mental health services easy through a simple referral process. As the team built back services, Puente prioritized the need in school communities. When the team began to be on campus and in classrooms, students, school staff, and their families began to seek out services again. The presence was hopefully seen as a normalization of seeking mental health services, which is a component of reducing stigma and discrimination.

As was noted, Puente's CMHW services are provided to anyone residing or working in the geographic region of Pescadero, La Honda, Loma Mar, or and San Gregorio. The South Coast is a multicultural community. Three CMHW clinicians are bilingual in English and Spanish, one is able to communicate with Spanish speaking parents and families (but not provide bilingual therapy), and three clinicians are monolingual English speakers. All CMHW clinicians are trained in cultural humility and through a diversity, equity, and inclusion framework which reduces language barriers and cultural biases. CMHW clinicians also completed required training in HIPAA/ confidentiality, child abuse prevention, and sexual orientation and gender identity expression. The CMHW staff clinicians supported the monthly Transforming Trauma and Stress series offered to all Puente staff. These sessions began in May 2022 and were led by a consultant with training in the Trauma Transformed model. All clinicians undergo extensive training in order to offer stigma-reducing services.

Increase number of individuals receiving public health services

Puente's health programs address social determinants of health such as access to health care services, transportation limitations, limited social support, language barriers, and cultural biases. Each social determinant increases participants' cumulative barriers to healthcare and their overall wellness. Puente enrolls participants in health insurance programs, arranges transportation to

medical services, and facilitates and hosts mobile medical and dental clinics in conjunction with the San Mateo County Health System and other providers. When a member of the mental health team notices a public health need, Puente's internal referral process allows for seamless linkage to health services as needed. Over the FY 2021-22, the CMHW team provided twelve (12) participants with links to other Puente services.

Reduces disparities in access to care

Nationally, the percentage of adults who had received any mental health treatment in the past 12 months increased from 2019 to 2021, among both adults of all ages (from 19.2% to 21.6%) and those aged 18–44 (from 18.5% to 23.2%) according to the Centers for Disease Control and Prevention, 2022. All La Honda Pescadero Unified School District students have access to Project SUCCESS. Puente's goal is to eliminate health disparities and improve access to healthcare services including mental health care. Puente seeks to improve participants' mental wellness and decrease long-term mental health problems. Puente improves individual and family mental health by providing on-site individual and group mental health services and Puente significantly reduces the disparities that exist by providing this ease of services. Since the pandemic, mental health services have been challenging to secure and it can be extremely challenging to navigate insurance and health care systems. At the beginning of the COVID-19 pandemic, the Puente CMHW team was able to initiate services with all participants referred (by self or other) within one week of the referral being received. For the first half of FY 2021-22, many new referrals were placed on a waitlist, due to limited staff. Once the second staff clinician started in December 2021 (and was able to begin seeing student referrals in March 2022), the waitlist was cleared, and services were initiated within one week again. While waiting during the fall of 2021, some participants either sought services through their own insurance or waited three months to be seen by a CMHW therapist.

Implements recovery principles

Puente provides alcohol and other drug referral services as needed. Puente also recognizes that recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. Puente's service continuum promotes the four major dimensions that support recovery:

- Health as defined by overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being. Puente's Community Mental Health and Wellness and Community Health team makes physical and mental health care accessible to the community. In partnership with San Mateo County, Puente offers free medical clinics on the San Mateo South Coast and offers free and accessible health services.
- Home as defined by having a stable and safe place to live. Puente's financial assistance programs provide rental assistance to those struggling with housing stability. Puente's easy internal referral system makes access to these services seamless for participants.

- Purpose as defined by conducting meaningful daily activities and having the independence, income, and resources to participate in society. Puente's education programs and safety net services support participants in attaining purpose. Services include tutoring, financial planning/budgeting, individual tax return preparation, and technical assistance for job seekers.
- Community as defined by having relationships and social networks that provide support, friendship, love, and hope. Community is at the center of Puente's mission and vision, empowering community members and being a local resource is a sense of pride for Puente. Puente seeks to reduce health disparities in the community through access to services.

Other activities that benefit SUCCESS participants

Given the high levels of anxiety and uncertainty in students, as reported by school staff and observed by clinicians seeing students in therapy, Puente's CMHW team piloted an additional Social Emotional Learning Tier 1/ universal program called *Start Up!* in the spring of 2022. This curriculum is based on an evidence-based Neurodevelopmental Art Therapy (NDAT) chronic trauma treatment model designed to strengthen neural pathways; reduce anxiety, depression, and aggression; and support students' academic success. The program was originally developed for Native American communities but was adapted to cultures and ethnicities of any community, as the curriculum is designed to be culturally neutral and respectful of all beliefs and values. The program is also designed through a trauma-informed lens and utilizes evidence-based research on trauma's impacts on the brain and how art therapy activates the brain to promote healing and neuroplasticity. The pilot *Start Up!* program, totaling 33 sessions, was offered to all Transitional Kindergarten (TK) - 5th grade students at Pescadero Elementary School, a classroom of 7th graders and a high school art classroom at Pescadero Middle/High School, reaching an additional 110 students.

The CMHW team revised the referral process, creating new information sheets that described therapy services and updating the referral and consent forms so that they were current with legal and ethical requirements. Additionally, the forms were split into referrals for general community members and LHPUSD students. The new LHPUSD student referral and consent forms allow clinicians to consult with school staff on an as-needed basis without a separate release of information that previously needed to be signed prior to communicating with school staff. All forms are in English and Spanish and are available to pick up from Puente's Pescadero and La Honda offices, from each school site, and can also be mailed to participants.

Successes

The FY 21-22 was filled with many successes for Puente:

- The new community-based initiative, *Pandemic Stress, Fatigue, and Trauma: Healthy Practices for Uncertain Times*, was provided for 28 Puente staff, most of whom live in the community, and 17 youth ages 16-25 participating in Puente's Education Y.E.S. summer program. All

sessions were provided in English (with Spanish translation for Puente staff) and included Wellness Kits to support positive mental health practices. The CMHW team aims to offer these sessions to the general community and customize them for targeted groups, like La Sala and the 60+ program, in the next year. On average, a majority of participants rated the trainings positively (Excellent = 29%, Good =57%, and Average = 14%).

- School Community Engagement: At the end of the school year, the CMHW team created specialized Wellness Kits for 79 LHPUSD school staff as an offer of support for those who managed a school year that came with many challenges no one anticipated, especially after a challenging year before. The Wellness Kits included creative and supportive materials as invitations for school staff to take time for self-care and restoration over the summer.
- Updated Curriculum: In addition to providing Project SUCCESS programming, Puente's CMHW team partnered with The Addiction Education Society to provide additional curriculum, Neuroscience of Addiction, to 8th graders, allowing for a more current approach to PEI information. Students were highly engaged in understanding how addiction is influenced by brain development and learned more about evidence-based resistance strategies.
- Telehealth: Puente continued to offer flexible telehealth sessions, allowing for community members to access mental health services at more convenient times and without commuting to the office. This shift to telehealth at the beginning of the pandemic, also allowed for contractor clinicians to see more participants because they were not limited by their time in the office. The team was also able to contract a part-time bilingual English-Spanish licensed clinician who could see monolingual community members with complex trauma issues.

Challenges

- Staffing: a new full-time Clinical Director started in September 2021, after nearly a year with an interim contractor providing support, during a time when in-person services were suspended. Three staff clinicians left the CMHW the summer before, leaving one staff clinician with a full caseload. Four contractor therapists continued seeing participants in individual telehealth sessions. A second clinician was hired in December 2021 and was prepared to begin seeing students referred for therapy services (many of whom had been waiting for up to three months), only to be put on hold because of because of the Omicron variant spike and the decision to wait until the transmission rates were lower to restart. The team continues to seek at least one more additional bilingual English-Spanish clinician in the face of a state- and nationwide shortage of mental health providers. Additionally, the Clinical Director experienced a family emergency that resulted in time away from the CMHW program during the second half of FY 2021-22. Additionally, the core staff clinicians are not bilingual Spanish-English speakers and rely upon translation services (over-the-phone and an in-person translators) to communicate about the services with participants, their families, and during

Puente staff meetings, but not for therapy services. Only the bilingual clinicians provide therapy in Spanish.

- COVID-19: Safety protocols prevented in-person services for most of the school year. The CMHW team recognized the need for providing services in-person and were frustrated with the ever-changing level of COVID-19 transmission in the community that resulted in continuing to offer virtual services. For example, several small social emotional support groups were formed in both elementary schools in late October 2021, with participants meeting weekly for 6 weeks until the Omicron variant cancelled all in-person services. This included students who were getting started again with in-person therapy sessions who were suddenly faced with either waiting for the latest surge to decline or move to telehealth, which was already a challenge for this age group.
- Scheduling: When the risk lowered significantly by March 2022, the team moved quickly to schedule Project SUCCESS with school staff, at a time when academics and other programming was also important. School staff were flexible and adaptable with the Project SUCCESS requests, dedicating some class time for the CMHW team to provide in-person sessions. All school principals agreed to begin planning sessions in August 2022, to better prepare and schedule ongoing school activities for the upcoming school year of 22-23.

TRAUMA-INFORMED CO-OCCURRING SERVICES FOR YOUTH

Trauma-Informed Co-occurring Services for Youth target youth and transitional age youth (TAY) ages 15-25 who are at greatest risk for adverse childhood experiences; children of color and children who grow up in poverty show the greatest risk for ACEs. Other groups can include juvenile justice involved, immigrant youth, homeless youth, youth in foster care, etc. Trauma-Informed Co-occurring Services for Youth consists of three required components: Group-Based Intervention; Community Engagement; and Social Determinants of Health (SDOH) Screening and Referrals.

- The **Group-Based Intervention** component utilizes evidence-based or promising practice intervention or curriculum to address trauma and co-occurring substance use issues with youth. Agencies can opt to provide the Mindfulness-Based Substance Abuse Treatment (MBSAT), which was piloted with youth throughout San Mateo County or an alternate culturally-relevant intervention/curriculum. Agencies target at least 8 youth per cohort and each cohort consists of at least 8 sessions for the intervention and 1 session for youth engagement opportunities.
- The **Community Engagement** component address community-level challenges that are necessary for positive youth outcomes. Agencies provide at least two foundational trauma-informed trainings for adults that interact with their youth cohort participants (parents, teachers, probation officers, service providers, etc.) to create trauma-informed supports for

youth. This component also encourages agencies to connect the cohort youth to leadership opportunities such as the BHRS Office of Diversity and Equity (ODE) Health Ambassador Program for Youth and the Alcohol and Other Drug (AOD) youth prevention programs.

- The **Social Determinants of Health (SDOH) Screening and Referrals** component acknowledges that social determinants of health (e.g., food insecurity, housing, transportation, medical treatment, etc.) can account for up to 40 percent of individual health outcomes. Agencies screen youth participants at to support appropriate referrals and identifying community-based social service resources and social needs and/or gaps.

Four agencies provide interventions as follows:

- Mindfulness-Based Substance Abuse Treatment (MBSAT)
    - StarVista provides 6 cohorts per year in North County and South County
    - Puente de la Costa Sur provides 2 cohorts per year in the South Coast region
    - YMCA Bureau of San Mateo County provides 2 cohorts per year in South San Francisco
- Panche Be Youth Project
    - The Latino Commission provides 2 cohorts per year: 1 cohort Xinachtli for girls and 1 cohort of El Joven Noble curriculum for boys in Half Moon Bay.

MINDFULNESS-BASED SUBSTANCE ABUSE TREATMENT (MBSAT)

MBSAT is a group-based curriculum incorporating mindfulness, self-awareness, and substance use treatment strategies with adolescents dealing with substance use/misuse. MBSAT provides adolescents with the ability to improve their decision-making skills and reduce unhealthy behaviors through learning emotional awareness and choosing how to respond (versus react) to stressful situations, how specific types of drugs affect the body and the brain, and how family, peers, and the external environment can contribute to drug use. MBSAT strives to offer youth an empowered approach to substance use prevention rather than programs that teach “just don’t do (drugs).” MBSAT is designed for use with adolescents and uses adult facilitators to model authenticity and build healthy relationships.

MBSAT – PUENTE DE LA COSTA SUR (PUENTE)

MBSAT is designed for use with adolescents and young adults, ages 15-25, and uses adult facilitators as leaders of the group to model authenticity and building healthy relationships. Puente’s Community Mental Health and Wellness (CMHW) clinical staff, trained in cultural humility and trauma-informed care, facilitate this group. All Puente CMHW staff are either licensed or pre-licensed by the Board of Behavioral Sciences. MBSAT is offered to high school students in the La Honda-Pescadero Unified School District (LHPUSD), as well as young adults in the community.

Program Impact

MBSAT - Puente*	FY 2021-22
Clients served (unduplicated)	34
Cost per client	$882
Individuals reached (duplicated)	0
Total Served	34

** Unduplicated clients served are the youth that participated MBSAT group sessions, individuals reached would include community member trauma-informed presentations to support youth. This was not provided in FY 2021-22 due to staffing challenges*

Outcome Indicators

Puente reported combined Project SUCCESS and MBSAT data. Future annual reports will request separate data for each program. Puente was unable to report on general mental health outcomes for the individual and group therapy participants. Puente's Community Mental Health and Wellness (CMHW) clinicians were inconsistent in their collection of the PHQ-9 and GAD-7 throughout the year and the metric was finalized in the spring of 2022. Staff will receive an overview training of these assessments, so that clinicians can begin to collect this data in FY 2022-23.

Domain	Indicators/Questions	#	%
Self-Empowerment	I learned about myself and my thoughts and feelings in this program (5th graders, n=15)	4	36%
	I learned about myself and my thoughts and feelings in this program (8th graders, n=19)	5	26%
	Being in this program helped me understand how to better manage how I respond to my thoughts and feelings (5th graders, n=15)	4	36%
	Being in this program helped me understand how to better manage how I respond to my thoughts and feelings (8th graders, n=19)	9	47%
Improved knowledge,	Because I was in this program, I learned skills that help me express my emotions and opinions more effectively (5th graders, n=15)	4	27%

skills, and/or abilities	Because I was in this program, I learned skills that help me express my emotions and opinions more effectively (8th graders, n=19)	6	32%
Stigma Reduction	Because I was in this program, I feel more comfortable talking about challenges with using alcohol and/ or drugs (5th graders, n=15) Because I was in this program, I feel more comfortable talking about challenges with using alcohol and/ or drugs (8th graders, n=19)	5 4	33% 21%

***The development and implementation of the PEI Reporting Frameworks occurred late in the reporting period, so the data is not representative of the full reporting period.

Demographics

Puente was not able to collect information for demographics due to staff shortages at the time the data template was finalized. Puente's Community Mental Health and Wellness (CMHW) team welcomed a Program Associate in August 2022, whose primary focus is supporting clinicians with administrative tasks, including collecting this level of data for program participants. The Clinical Director will be working with the Program Associate and CMHW clinicians to ensure that all demographic data will be collected on an ongoing basis through next reporting period.

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals			
Substance Use Disorders (SUD) Referrals			
Other Mental Health (MH) Referrals		1	1
TOTAL		1	1

Referrals to Other Services

Puente was not able to collect information for the Social Determinants of Health Screener, which would bolster referrals to other services, due to staff shortages at the time the data template was

finalized. The CMHW team welcomed a Program Associate in August 2022, whose primary focus is supporting clinicians with administrative tasks, including collecting this level of data for program participants. The Clinical Director will be working with the Program Associate and CMHW clinicians to ensure that all demographic data will be collected on an ongoing basis through next reporting period.

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services		Legal	1
Financial/ Employment	3	Medical care	1
Food	5	Transportation	0
Form assistance	2	Health Insurance	0
Housing/ Shelter	1	Cultural, non-traditional care	0
Other	0	**TOTAL**	**12**

Program Narrative

The primary program activities this fiscal year included MBSAT three-day training for all clinical staff. Dr. Himelstein addressed the unique challenges posed by the pandemic in offering the MBSAT curriculum and provided alternative implementation strategies that included utilizing the curriculum in individual sessions as well as modifying the curriculum by either combining modules or only including modules that seemed particularly applicable to the youth being served. The MBSAT program was provided to Puente clients individually and in small group format. Program activities included a combination of experiential, didactic (psychoeducation), and process-based interventions. These included formal meditation (mindful breathing, body-scans, noting/labeling, and compassion-based meditations), emotional awareness/ processing activities, informal mindfulness activities, and the dissemination of information to youth (defining mindfulness, exploring the relationship between drugs and the brain, etc.), as well as processing with youth how their environments influence them and vice-versa. The 12 sessions in the MBSAT curriculum manual were covered: Introduction to the Program, Mindfulness of Drugs and their Health Effects, Reacting Vs. Responding, Mindfulness of Delusion, Emotional Awareness, The Brain and Drugs, Mindfulness of Cravings, Mindfulness of Triggers, The Family System and Drugs, Mindfulness of the Peer System, Mindfulness of the External Environment, and Closing Ceremony.

In spring of 2021, a teen who lived in another city in San Mateo but who had close ties to the La Honda community overdosed. Puente's BHRS team, parents, and educators collaboratively decided on an in person drop-in group for the La Honda teens would support community healing. This 1.5 hour group was provided in person at the La Honda office for 8 weeks. The team adjusted the group format to include both MBSAT curriculum and grief support. Survey data was not collected due to the

sensitive nature of the group and to encourage attendance. Community parents also provided dinner each week to encourage attendance. A small stipend ($15/per group) was also offered for attendance.

Improves timely access and linkages for underserved populations:
Puente's service region is home to San Mateo County's most underserved population. Participants face numerous challenges to accessing health care, including behavioral health care. South Coast residents with low socioeconomic status are more likely than higher-status groups to have access issues, such as the absence of health insurance and inadequate transportation to medical appointments. Moreover, individuals who do not receive health insurance subsidies, such as undocumented immigrants, often lack the means to pay for health care. In addition to working physically demanding low-wage jobs, many participants are non-English speaking immigrants who have experienced multiple stressors and trauma.

All students and their families (ages 9-18) in the school district have access to Puente counseling services. There is no barrier to access for participating in treatment at Puente. MBSAT is provided to those youth who would benefit from psychoeducational and support around substance use.

By providing free behavioral health care to all residents in the service area, Puente ensures that vulnerable SMC community members have access to the mental health services they need. Services were primarily accessed via telehealth over the FY 2021-22 due to the COVID-19 pandemic. Puente mitigated access issues by offering the community hotspots and tablets when necessary. A major challenge in this area was the lack of connectivity (internet or cellular) in some regions of the South Coast, adding challenges to reaching participants. The Puente clinical team was creative in connecting with participants by making multiple attempts through various means (text, WhatsApp, email, and voicemail). The online nature of services may also have hindered some access for individuals who felt uncomfortable with the new technology.

Reduces stigma and discrimination:
Puente's BHRS services provide an opportunity for students and their families to engage with trained mental health clinicians in an educational format, workshop format, and therapeutic sessions to build relationships that break down the stigma of mental health issues and reduce the stigma for seeking treatment. The Puente BHRS team promotes mental health awareness, provides education in accessible formats, and makes access to mental health services easier through a simple referral process. By embedding mental health awareness and mental health clinicians in existing community forums such as the weekly farmworker La Sala program, the vaccine, and food distribution sites and classrooms, the mental health team is seen "as part of" not "separate from" the community and in this way directly able to reduce stigma.

The MBSAT curriculum provides psychoeducation and a harm reduction model for substance use services. The non-stigmatizing and non-pathologizing aspect of the curriculum supports inclusion and exploration of issues versus an abstinence model, which can deter some individuals from seeking

support. Puente BHRS services are provided to anyone residing or working in the geographic region. The South Coast is a multicultural community. Sixty-six percent of the BHRS staff are bilingual in English and Spanish. All BHRS clinicians are culturally competent and trained through a diversity, equity, and inclusion framework, which reduces language barriers and cultural biases.

Increases number of individuals receiving public health services:
Puente's BHRS services provide students and families with referrals for physical health, behavioral health programs, safety net services, and education programs.

Puente's health programs address social determinants of health such as access to health care services, transportation limitations, limited social support, language barriers, and cultural biases. Puente's health program recognizes the social determinants that affect participants' ability to access healthcare and maintain their health. In addition to working physically demanding low-wage jobs, many participants are non-English speaking immigrants who experience multiple stressors and trauma. Each social determinant increases participants' cumulative barriers to healthcare and their overall wellness. Puente enrolls participants in health insurance programs, arranges transportation to medical services, and facilitates and hosts mobile medical and dental clinics in conjunction with the San Mateo County Health System and other providers. When a member of the behavioral health team notices a public health need, Puente's internal referral process allows for seamless linkage to health services as needed.

Reduces disparities in access:
Behavioral Health is a high priority need area for San Mateo County (Stanford Community Health Needs Assessment Report, 2019). Through Puente's BHRS services, all La Honda Pescadero Unified School District students have access to this program. Puente aims to eliminate health disparities and improve access to healthcare services for vulnerable populations on the South Coast, including behavioral health care. By providing greater access to behavioral health care services, Puente seeks to improve participants' mental health and decrease long-term mental health problems. Puente improves individual and family mental health by providing on-site individual and group behavioral health services, and Puente significantly reduces the disparities in the behavioral health system. During the COVID-19 Pandemic, the Puente BHRS team initiated services with all participants referred (by self or other) within one week of the referral being received.

Implements recovery principles:
Puente's BHRS team provides a continuum of services from prevention, early intervention, and treatment. The MBSAT curriculum is psychoeducation and skill-building substance use intervention program that supports recovery services. Puente provides alcohol and other drug referral services as needed. Puente also recognizes that recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. Puente's service continuum promotes the four major dimensions that support recovery:

- Health is defined by overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being. Puente makes physical and mental health care accessible to the community via free medical clinics, has championed the vaccination effort on the San Mateo South Coast, and offers free and accessible health services.
- Home is defined as having a stable and safe place to live. Puente's financial assistance programs provide rental assistance to those struggling with housing stability. Puente's easy internal referral system makes participants' access to these services seamless.
- Purpose is defined by conducting meaningful daily activities and having the independence, income, and resources to participate in society. Puente's education programs and safety net services support participants in attaining purpose. Services including but not limited to tutoring, financial planning, individual tax return preparation, and technical assistance for job seekers are all accessible to all Puente participants.
- Community is defined by having relationships and social networks that provide support, friendship, love, and hope. Community is at the center of Puente's mission and vision; empowering community members and being a local resource is a sense of pride for Puente. Puente seeks to reduce health disparities in the community through access to services.

Successes

Crisis Consultation: Puente CMHW staff also continued to provide teacher and school consultation. Building on the previous year's decision to not provide crisis response, the team was able to support school staff, families, and community members in reaching the most appropriate services, including StarVista's Crisis Center and their new Youth S.O.S. outreach, and San Mateo County's PERT.

Staffing: After nearly six months of seeking a new clinician to hire, Puente hired an Associate Marriage and Family Therapist and Provisional Registered Art Therapist who has extensive experience with elementary, middle, and high school students.

Teen Wellness Spaces: In January 2022, the CMHW team committed to creating teen wellness spaces in Puente's La Honda office and in the Pescadero CMHW building. By June 2022, the Pescadero office was redesigned so that the open area had a sitting area (small couch, comfortable chairs, and a coffee table), a worktable and chairs for up to 12 people (likely to be 6 during COVID-19), and bookcases containing a lending library with youth and young adult mental health resources. There are also soothing elements (water fountain, Zen sand garden) and warm lighting to create a welcoming and calm atmosphere. During FY 2022-23, the CMHW team will be recruiting youth to advise us on ideas for refreshing the La Honda space, as well as programs and activities that would benefit more young people. With the La Honda office designated as a youth wellness space, the CMHW team

intends to create a central location for young people to hang out and engage in positive activities, including MBSAT groups, since this community specifically has very few spaces for youth to congregate.

Challenges

In prior years, the MBSAT activities included, combination of experiential, didactic (psychoeducation), and process-based interventions, like formal meditation (mindful breathing, body-scans, noting/labeling of feelings and emotions, and compassion-based meditations), emotional awareness/processing activities, informal mindfulness activities, and the dissemination of information to youth (defining mindfulness, exploring the relationship between drugs and the brain, etc.), as well as processing with youth how their environments influence them and vice-versa. The 12 sessions in the MBSAT curriculum manual are typically offered in the following order: Introduction to the Program, Mindfulness of Drugs and their Health Effects, Reacting Vs. Responding, Mindfulness of Delusion, Emotional Awareness, The Brain and Drugs, Mindfulness of Cravings, Mindfulness of Triggers, The Family System and Drugs, Mindfulness of the Peer System, Mindfulness of the External Environment, and Closing Ceremony.

However, The MBSAT Community Engagement component was not provided to Puente community members in FY 2021-22. The CMHW team faced several challenges, including having a relatively new team (only one staff clinician remained from the previous year's MBSAT programming) and the team remained understaffed throughout the year. In addition, there appeared to be a lack of interest from the young adults from La Honda who participated in last year's MBSAT program in attending another round of groups, and the ongoing varying levels of COVID-19 transmission rates in the community impacted CMHW's clinicians from providing in-person services and getting to know community members to recruit new participants.

Participant interest: With a combination of staffing changes, severely reduced contact with students, and scheduling issues, the CMHW team was unable to recruit participants for the MBSAT program. CMHW clinicians checked in with participants from the previous year's MBSAT group, specifically students who are part of a tight-knit community in La Honda that experienced the death of a young person the previous year. Fortunately, this group reported feeling supported by their peers, their families, and school community, and declined to participate in another group. Project SUCCESS, which introduces the language of drug and alcohol prevention, was delivered to 8th graders at the end of the school year, leaving little time to form a MBSAT group. In January, Puente committed to creating teen wellness spaces in both the Pescadero and La Honda offices and aims to recruit a small group of youth next fiscal year to give input about needed mental health services and to participate in MBSAT programming.

MBSAT - STARVISTA

MBSAT is offered as part of the StarVista Insights Program. The purpose of the Insights Program is to improve the lives of transition-age youth (TAY) who are dealing with issues around substance use, trauma, emotional regulation, family conflict, unhealthy relationships, and/or any other factor limiting their healthy development and overall happiness. Their mindfulness groups focus on important life skills such as self-awareness, enhancing emotional well-being, and reducing substance-use though healthier coping mechanisms and informed decision-making. With the right tools, youth can better manage life challenges in the moment instead of allowing emotions to lead to poor judgement, risky decisions, and eventually negative or dire consequences.

Group facilitators work with participants to understand that mindfulness is a broad term that touches on practices that range from formal meditation to making informed, on-the-spot decisions. A favorite tool to teach youth is the TAP acronym. It stands for Take (a breath), Acknowledge (the situation), and Proceed. This TAP acronym is also shorthand for popular slang youth use when they need to check in with others or themselves: They will say something like “let’s tap in” to mean that they’d like to know what’s going on/catch-up, check in. This popular youth slang is used as a bridge to a new practice. Calling on the TAP acronym can support youth to make better decisions in the heat of a risky situation. It is this kind of practical use of mindfulness that is important to bring to youth. After all, at its most basic, it means to be present to whatever is unfolding with an attitude of non-reactivity and non-judgment. This produces a state of equanimity and calm, a disposition which most decision-making can benefit from.

The curriculum covers topics of substance use, cravings, triggers, emotional awareness, brain function, family systems, peer systems and environmental influences on behavior. Each group provides an opportunity to explore multiple meditation interventions focusing on specific practices, such as but not limited to meditation of the breath, body, and environment. By providing youth with the space to calmly explore their true internal states, (and therefore limitations and challenges but also goals and strengths) they can bring the fruits of their insights into their everyday experience through better choices. So often, negative experiences come down to split decisions made in a momentary lack of clarity and poor judgement, leading to many more moments of anguish and discomfort. With continued utilization of these strategies towards managing their intrapersonal and interpersonal relationships and an ongoing commitment to self-understanding and actualization, youth can change begin to transform their lives towards greater agency and overall well-being.

Over the last year and a half, with the appropriate safety protocols in place, staff have been able to provide in-person services for clients who feel that this is most conducive to a better experience. The program material has been adapted to deal with the challenge of the ongoing COVID-19 pandemic. Staff are working diligently to continue to bring support emphasizing emotional regulation to help youth cultivate and grow their resilient capacities during these uncertain times.

To ensure steady yet sustainable growth of the program, staff are ramping up offerings of mindfulness groups for TAY youth by working with various community-based organizations and school districts. Any transition-aged youth (typically ages 15-25) are welcome to participate, and staff are open to working with any organization serving this population. Their commitment to work with diverse community sites (school, afterschool program, transitional housing program, etc.) has led to an increase in the number of youths served (104 participants during the fiscal year). Groups are organized to make the setting age-appropriate (groups are composed of individuals ages 14-17 and 18-25). Currently, clinicians are traveling to various sites, and the hope is to return to these sites and extend beyond them to serve anyone who can benefit from these services.

Program Impact

MBSAT - StarVista*	FY 2021-22
Clients served (unduplicated)	93
Cost per client	$968
Individuals reached (duplicated)	11
Total Served	104

** Unduplicated clients served are the youth that participated MBSAT group sessions, individuals reached would include community member trauma-informed presentations to support youth. This was not provided in FY 2021-22 due to staffing challenges*

Outcome Indicators

Domain	Indicators/Questions	# Agree	%
General mental health	Due to this program, I am better able to participate in daily life.	80	91%
	Due to this program, I feel good about my future	75	85%
Self-empowerment	Due to participating in this program, I overcome challenges in a more positive way	82	87%
	Due to this program, I take responsibility for what I do	88	100%
	Due to this program, I tell the truth even when it is not easy	82	93%
Knowledge/ skills and/or abilities	Due to participating in this program, I feel in control of my life and future	78	87%
Connection & Support	Due to participating in this program, I build friendships with other people	82	93%
	Due to this program, I resist bad influences	82	93%

Community/ Advocacy	Due to this program, I think it's important to help other people	88	87%
Knowledge & Access to Services	Due to participating in this program, I stay away from tobacco, drugs, and alcohol Due to this program, I plan ahead and make good choices	78 81	87% 92%
Cultural Identity/ Humility	Due to this program, I accept people who are different from me	88	100%
Stigma Reduction	Due to this program, I express my feelings in a proper way Due to this program, I seek advice from people I look up to	75 79	85% 90%

***The development and implementation of the PEI Reporting Frameworks occurred late in the reporting period, so the data is not representative of the full reporting period.*

Demographics

Age	%	Race	%
6-15yo	30%	American	9%
16-25yo	70%	Latinx	23%
Primary Language	**%**	Indigenous	11%
English	94%	Pacific Islander	32%
Burmese	2%	White	23%
Tagalog	2%	Other	2%
Portuguese	2%		
Sex Assigned At Birth	**%**	**Ethnicity**	**%**
Female	42%	African	4%
Male	55%	Asian	28%
Decline to state	3%	Chinese	4%
Intersex	**%**	Central American	9%
Yes	4%	European	21%
No	89%	Filipinx	11%
Decline to state	7%	Chicana	23%
Gender Identity	**%**	**Disability**	**%**
Woman	38%	Difficulty seeing	15%

Male/Man/Cisgender Man	53%	Difficulty hearing or having speech understood	2%
Questioning or unsure	2%	Another (write-in)	9%
Decline to State	8%	Decline to State	9%
Pansexual	2%	No	65%
Decline to state	6%	**Veteran**	**%**
Sexual Orientation	**%**	No	96%
Asexual	2%	Decline to state	4%
Bisexual	13%	**City/Region**	%
Gay or Lesbian	2%	North	62%
Heterosexual	75%	South	38%

** Unable to collect demographic data for about 20 percent of clients served. The goal moving forward is to have the first session where all forms are completed.*

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals	2	0	2
Substance Use Disorders (SUD) Referrals	1	0	1
Other Mental Health (MH) Referrals	0	0	0
TOTAL	3	0	3

Referrals to Other Services – Did not start utilizing the form until the end of the fiscal year.

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	0	Legal	0
Financial/ Employment	0	Medical care	0
Food	0	Transportation	0
Form assistance	0	Health Insurance	0
Housing/ Shelter	0	Cultural, non-traditional care	0
Other	0	**TOTAL**	**0**

Improves timely access and linkages for underserved populations:
Many clients are the first in their families to access services. StarVista works with partner agencies and individual participants to determine the best date/time/access point for participation. Additionally, now the program provides an online/at-home format allowing for greater reach and accessibility for those clients and/or programs with interest in telehealth services. Through a special grant, StarVista has been able to secure cellular phones with cameras for clients who indicate that they would most benefit from remote services due to transportation issues but do not have a phone of their own.

Reduces stigma and discrimination:
The mindfulness program is not focused on "telling youth what to do and what not to do". This approach is helpful in reducing internalized shame/shame directed at youth because by leading with this, they do not feel like their choices are being perceived as "good" or "bad" or scrutinized for morality or worthiness. By working with youth to understand the influence of personal, familial, societal, and systemic pressures on their everyday decision-making abilities, counselors can also work with them to find those key moments where they can exercise agency and choice within the myriad social, political, and economic dynamics at play. While they can recognize their agency, they can also see that some of their choices are heavily pressured by external factors. Taking all this into account, the program focuses on developing a practice of making more informed decisions – decisions that are based on desired long-term outcomes, rather than immediate gratification or reactivity.

The program encourages a high level of peer engagement, thus creating a deeper rapport, comfortability, and safety for participants. Facilitators steer away from strict didactic top-down approaches where the clinician/authority figure is the source of knowledge. This approach creates a socio-corrective experience for youth which they are not accustomed to but is believed to be imperative in reducing stigma; if youth can speak to their life experiences with authority, they can begin to take control and feel pride in their self-awareness and future decisions- the opposite of shame. By working closely with others in similar situations, youth can see that they are not the only ones dealing with difficult situations; there are others with whom to share without the judgement they may expect from others who do not share their experience. These kinds of connections among participants help normalize the kinds of conversations that the program supports (motivations for drug use, healthy coping, problem-solving, healthy decision-making, etc.) beyond the life of the program.

As has been seen, the onset of the COVID-19 pandemic has normalized conversation around mental health to a high degree. Many youth that have been involved in the juvenile justice, probation, homeless networks, foster care, etc. have expressed feeling powerless within those systems. As noted above, this program provides TAY with the psychoeducation, skill-building and decision-making abilities needed to overcome obstacles leading to their own solutions and positive outcome, and thus, a sense of empowerment and self-definition. Furthermore, the conversations and skills taught in the program can help participants to better contextualize their past experiences as the result of

not having the proper resources or tools along their own personal choices rather than just some inherent flaw in their character or a reductive attribution to personal choices. In this way, the hope is to help them destigmatize not only their present and future, but also their pasts.

Increases number of individuals receiving public health services:
Since the program launched remote services due to the COVID-19 pandemic, there has been a greater capacity to reach homes with already limited accessibility due to transportation issues. Many homes have trouble with consistent transportation, time shortages due to unpredictable or fluctuating parent work schedules or having to tend to the needs of more than one child in the home. StarVista collaborates with partner sites, other StarVista programs, and makes referrals to other county services/programs to coordinate the appropriate level of care for all participants.

Reduces disparities in access to care:
This program directly increases the number of individuals receiving services by targeting underserved populations. Transportation can often be a barrier to access and increases these disparities for young people with limited resources. This program travels to the participants, removing transportation as a challenge in accessing services. Additionally, their online platform offers a variety of time slots to accommodate the variety of work schedules, home-life schedules, and school schedules. They can also provide phones for youth who need a cellular device to participate in remote services.

Implements recovery principles:
By emphasizing increased awareness and acceptance as core elements of mindfulness, individuals can patiently implement critical principles to their recovery. Teaching mindfulness encourages the implementation of self-actualized, self-directed factors that the individual identifies through the recovery process. Mindfulness is rooted in holistic, strength-based, person-centered, and self-directed elements – all key principles of recovery.

Other activities that benefit clients
Clinicians support the client by accessing services and resources as needed. Case management services are provided outside of the group so that clinicians can assess the best resources and services that can meet their needs. Clinicians also work with participant's parents to access resources such as medical and or mental health counseling for themselves, the latter is seen as deeply connected to the youth's success in the program.

Successes

The clients in one of the most memorable groups showed openness to learn utilizing expressive activities as the clinicians who led this group incorporated sensory/ tactile activities this aided group members to utilize mindfulness. The activities that utilized various senses encouraged clients to increase participation and in turn increase vulnerability and transformed the group into a safe container to process their emotions, behavior, and thoughts. This kind of rapport led to productive

cohesiveness in group discussions. During a few instances, a group member was in crisis from overwhelming emotion. Fellow group members were able to support the group member(s) through the client's expression of their feelings in a compassionate and empathetic manner. Group members actively contributed to discussions about how they planned to use the curriculum outside/beyond substance use, reacted enthusiastically about ideas shared by members, and encouraged one another throughout this discussion. Due to the safe space created, there were a few youths who asked to stay in the group for a second round to explore the mindfulness group more in depth.

Challenges

During the first phases of the groups, some members were sensitive to the presence of other members who had a different demeanor or personality style. If active, outspoken members were present, the more timid or quiet participants felt encouraged to open up and speak but if they were absent, the others tended to be more reserved, resulting in lower engagement. To improve engagement, clinicians took time to balance rapport building and the curriculum to increase comfort in the group to express feelings, thoughts, and experiences from all members. Another challenge clinicians managed was a difficulty engaging a particular group that had a mixture of members who were participating in the group a second time and were familiar with the content. Clinicians were able to use the familiarity of the more seasoned participants as a strength by providing some leadership roles that allowed these youth to help with small tasks to keep everyone appropriately engaged.

Although much of the outreach done with new programs and schools indicated that many are interested and would move forward with implementation, many schools and programs are dealing with the challenges of returning to in-person instruction and staff shortages. The Wellness Teams at various sites often were very busy and did not have time to coordinate with us. The process for outside contractors to provide services can be quite extensive and time consuming. Additionally, communication is to be sometimes intermittent and if many people are involved, it can become fragmented. Sites are enthusiastic about adding this service to their campus, just strapped for time. The hope is to start coordinating with the Wellness Teams at the sites sooner in the year.

On a very different front, some clients come to group with a lack of clarity and/or ambivalence about mindfulness topics and how to utilize the practices in their day to day lives. Staff are working through this, but as of now, they see it as something very foreign to their own experience. One solution found was to focus on mindfulness vs strict meditation, which is what most people think of when they hear the word "mindfulness". Most often clients do not understand that mindfulness can be practiced in various settings and have not had the opportunity to learn without worrying of doing it "right." As mentioned before, at its most basic, it means to be present to whatever is unfolding in front of us with an attitude of non-reactivity and non-judgment.

Lastly, facilitators do not yet have a consistent group of kids showing up to sessions every week. Group members have varied throughout, and this means that sometimes it dips down to 1 member. Having to plan group activities and anticipate a flux is a bit difficult, but clinicians are working on having a variety of activities that will work well even if just one student participates on a given week. Clinician plan to work towards greater consistency in group members in the future by working with point persons at the sites to provide reminders and incentives to youth.

MBSAT - YMCA

The Youth Service Bureau (YSB) is a part of Urban Services YMCA and provides school-based mental health services at three high school campuses in South San Francisco. The high schools served under this contract are South San Francisco High School and El Camino High School. The target population served are youths ages 14-18. High School Safety Advocate (SSA) services are available and open to all youth on campus. YMCA High School SSAs provide a range of services and groups on campus including the First Stop group which utilizes the Mindfulness Based Substance Abuse Treatment (MBSAT) curriculum for youth referred to school-based services for both prevention and substance use. Students are referred by school personnel, administrators, counselors, and/or parents.

The MBSAT curriculum and interventions can be delivered in a group setting or individually in order to best accommodate the student's needs. The purpose of the High School SSA program is to support high school youth with access to mental health support for early intervention and prevention by addressing critical safety concerns. SSA staff work in partnership with school personnel to create safe environments on campuses by intervening to stop fights, mediating conflicts through restorative justice techniques, and preempting potential bullying, self-harm, suicide, substance abuse, and providing alternative pathways to support high school youth in avoiding entering the criminal justice system. SSAs therapeutic program model enables staff to establish relationships that empower young people to work with a safe adult who can guide them through problem-solving and skill-building techniques designed to address challenges, both at school and at home. The overarching goals of the program are to:

- reduce youth violence, gang participation, substance abuse, and involvement in the criminal justice system
- identify any risk to self or others, and secure appropriate services to ensure youths' safety
- change at-risk youths' behaviors to increase personal responsibility, risk avoidance, protective behaviors, and resiliency
- provide developmental inputs to promote positive behavioral change: safe environments, supportive adults, and a variety of programs and interventions matched to youths' risk
- measure the impacts of those developmental inputs as indicators of positive behavioral change

The High School SSA staff connect with youth on campus through a variety of activities and interventions. Students identified as needing a higher level of care can be referred to the YMCA for outpatient individual or family therapy. A large portion of the work that YMCA High School SSAs do with students referred to the program can be seen as case management. The SSAs yield a high number of referrals and through assessment can determine how a student can be best served depending on the individual needs present. Referrals to outside agencies or resources are also possible. The YMCA also facilitates part of the Alternatives to Suspension (ATS) program in South San Francisco in partnership with the school district to offer a day of structured therapeutic support to address underlying causes of behavior and increase school success upon reentry for high school and middle school students that have been suspended. The YMCA's intention this year is to increase the connection and support for students suspended for substance use on campus to be referred to the high school SSAs for continued support with interventions and early prevention of more serious issues that include the use of the MBSAT curriculum. The following services are provided on campus by the High School SSAs.

- crisis intervention and mediation
- risk and mental health assessment
- on-campus First Stop groups, using MBSAT curriculum
- on-campus Girls United empowerment groups
- on-campus emotion regulation "CALM groups," based upon Aggression Replacement Therapy
- on-campus sexual violence prevention group, for any youth who may be exhibiting emerging problematic sexual behaviors like harassment and other boundary crossing behaviors.
- referrals for further individual and family counseling at the Youth Service Bureaus/YMCA clinics or with other appropriate services in the county
- family case management, including parent support and psychoeducation

Additionally, High School SSA staff provide outreach and education activities with schools to enhance strategies for reducing risk factors and substance use through discussions with students, workshops, and parent workshops.

Program Impact

MBSAT - YMCA*	FY 2021-22
Clients served (unduplicated)	6
Cost per client	$5,000
Individuals reached (duplicated)	0
Total Served	6

** Unduplicated clients served are the youth that participated MBSAT group sessions, individuals reached would include community member trauma-informed presentations to support youth.*

Outcome Indicators

The development and implementation of the PEI Reporting Frameworks occurred late in the reporting period, so the data is not representative of the full reporting period. This data will be collected moving forward for the current fiscal year.

Referrals

In general, the YMCA does not make SMI or SUD referrals due to the population served in the high school setting. Any referrals that could potentially be made would be for outpatient clinic services to the YMCA clinic. The YMCA is currently working to create additional assessments in the Electronic Healthcare Record (EHR) to capture Social Determinants of Health (SDOH). The YMCA has created post surveys for program participants to gather outcomes for increased protective factors and decreased risk factors. Surveys have been created for community participants in outreach and workshops as well. Since the population served are high school students there is typically no need for referrals for food, shelter, emergency services, legal, medical, etc. If there are any students requiring core service referrals, the referrals would be made to the YMCA Community Resource Center (CRC).

Demographics

Last November the YMCA completed the final stage of a YMCA organization wide EHR data migration from the previous cloud based EHR that was used for seven years prior. The transition and migration created challenges consisting of offline time, documentation timelines to adhere to, and training all YMCA staff and trainees on a new EHR system. The current challenges with specific data collection are due to the type of data collected in school-based settings. The YMCA is making efforts moving forward to create specific screeners and surveys in the new EHR system that can capture social determinants of health and more specific demographic data. The large scale multi phased project of the YMCA of San Francisco to create and integrate specific design and engineering requests for the MHSA program into the EHR system is a time-consuming project that will require patience as it continues to unfold. In the meantime, the YMCA will work to gather specific demographic and social determinants through a manual method in order to capture the needed data.

There continue to be challenges with the implementation of San Mateo County EHR Avatar for reporting purposes. Unfortunately, there was no progress made on installing Avatar EHR on YMCA devices reported from last FY 2020-21. The main challenges for FY 2021-22 occurred with the Avatar credentialing process through BHRS. Those challenges are still ongoing and present, although new contacts have been made recently with BHRS Information Technology (IT) department and will hopefully yield more progress moving forward. New credentialing forms were submitted to BHRS in August, the process has been slow to this point.

Program Narrative

YMCA High School SSAs receive a high number of referrals throughout the school year. All students referred to the SSAs are assessed, and the best course of action is determined. An advantage of the high school SSA program is that all students are old enough to consent to services on their own. Although every effort is made to include parents/caregivers, it does not have to delay timely access to services on campus. If it is determined that a student needs a referral or linkage to other services or resources, the SSA can initiate that linkage immediately in most cases. Most referrals for outpatient therapy services are made directly to the YMCA clinic. The YMCA clinic accepts Medi-Cal and offers fee for service options with a sliding scale for individuals and/or families requiring financial support.

If it is determined that the student would be better served with an outside referral, the SSA will provide appropriate referrals as needed. SSAs can also refer students to Care Solace, which provides linkage to community-based mental healthcare and providers through the school district. The combined efforts of the YMCA and the school partnerships work to reduce disparities in access to care. YMCA Community Resource Center (CRC) is a core service agency that provides food, housing/shelter resources, homeless services, short-term rental/deposit/mortgage assistance, and utility bill financial assistance to residents of South San Francisco, San Bruno, and Brisbane. If a student's family needs resources or referrals for any core services, linkage can be initiated in a timely manner.

The high school SSA program can help reduce stigma around mental health because the SSA is integrated into the school community and typically works in conjunction with the counseling team. For some students, knowing YMCA SSAs are a part of an outside agency can result in increased trust being built. Having a trusted adult on campus that can provide individual and/or group support can help normalize mental health services and provide opportunities for engagement that can create lifelong patterns of seeking help and support that can benefit young people. The fact that SSAs are not providing traditional therapy on campus helps to increase access as well as contribute to decreasing disparities to much needed services. YMCA staff and SSAs cultural backgrounds often reflect the students and families of the communities served and can increase engagement and connection to decrease stigma and discrimination.

The YMCA is committed to being a Trauma Informed System (TIS) and engages in cultural humility and racial equity practices and education for all staff and trainees. The two foundational principles of TIS are: understanding the nature and impact of trauma and recovery and recognizing socio-cultural trauma and structural oppression. This approach is practiced internally at the YMCA, and with students, clients, families, and all community partners. This approach acknowledges individual and systemic racism and oppression inflict trauma on students and families that are being served by the SSAs on campus. Efforts to recognize power and privilege, confront individual and systemic racism,

and promote anti-racism are practices employed to reduce discrimination and value the unique strengths and resilience in students who experience historical and current traumas.

The YMCA will continue to engage in racial equity work with hired consultants. In Phase One four specific growth areas were identified to focus on: evaluations, compensation, communication, and training. The hope is that this and improvements made in other areas will help to retain and attract staff, which ultimately benefits the students that YMCA serves. The YMCA is dedicated to hiring staff with whom students can identify. This can also increase engagement and self-esteem for students from traditionally marginalized Black, Indigenous, People of Color (BIPOC) communities. In order to sufficiently support BIPOC staff members, the YMCA must commit to racial equity in the workplace. Staff feedback received this year indicated that the culture created at the YMCA is one of the main reasons staff continue to be a part of the agency. Even staff who are leaving this year have expressed uneasiness about leaving behind such a strong work community and network of support. The YMCA is currently waiting on a grant from the county to continue consultation for Phase Three.

Successes

The following are from YMCA high school SSA at South San Francisco High School during FY 2021-22. Full names of clients are not used in order to maintain confidentiality. The direct quotes of the students being served and utilizing the MBSAT curriculum highlight how the ability to access substance abuse services on campus can reduce stigma and provide a safe and trusted adult to connect with.

This academic school year, I was able to conduct 2 First-Stop groups (one in Fall 2021, the other in Spring 2022) for a combined total of 5 clients from both groups. Due to the spacing limitations provided by the school's COVID safety measures, each group could consist of no more than 4 student members in my onsite school office. There, I first met with OT and KV.

OT and KV were 11th graders who had been referred to First Stop as OT had sold marijuana edible gummies to KV that resulted in them (gender non-binary) vomiting in class and being escorted to the emergency room that same day. Upon their return, KV was interrogated and searched until proof was found and a confession given implicating OT. The group lasted for 6 sessions and provided time for each to open up to the therapeutic process at their own pace. During the sessions, OT and KV regularly commented on how the open transparency of the space really allowed them to process their usage without fear of judgement or shame. Both were quoted as having said, "No one has ever given me space to talk about stuff like this before so freely." In the session, the curriculum was customized to their specific situation and explore topics regarding decision-making, harm reduction techniques, exploration of the impacts of general substance use, personal and familial beliefs regarding substance use, and reframing of their perceptions around the practice of meditation. By the third session, both clients had gained a deeper appreciation for the meditative practices that

were employed to open up each session. While the two clients did not take a posture of complete abstinence regarding substance use, they were able to gain a much stronger awareness of societal regulations and greater confidence in their decision-making processes to abide within those regulations for the sake of their future and current academic goals. Both were noted in their closing session to have shared the sentiment that this format of learning, sharing and engagement provided a greater sense of knowledge than any other class or program that they had received previously.

In the Spring of 2022, I had received a new roster of students and was able to select four students for the next First-Stop group. Unfortunately, due to attendance issues, the fourth student never made an appearance in the 8 sessions provided for this group. This group consisted of a 9th grader named SS and two 10th graders named FT and SR. SS had been referred for vaping and marijuana paraphernalia found on him after wreaking of the scent. FT and SR were referred under the suspicion that the two had been smoking vape products in the bathrooms and hallways of the school. While working with all three, each shared of their personal beliefs regarding their usage. While SR fervently admitted to never once having tried any substances, he was willing to stay in support of his friends and his own personal knowledge. All three boys were often known for cutting class but found themselves regularly on time (if not early); many times, without being called or reminded. During these sessions, individual stress triggers were discussed, how they come to identify those triggers, the process of interrupting those triggers, finding alternative ways to resolve stress, better understanding the impacts of their substance of choice, and discussing the impact of their choices on all communities and social groups. Similarly with the previous group, this group thoroughly appreciated the openness of the discussions had and were quoted as saying, “Man, why can’t teachers talk about this ‘stuff’ the same that you do Mr. G?” Also, the meditation practices used to open each session were well received and found to be “restorative” and “relaxing AF”. While this group didn’t make any promises of abstinence either, they did agree that their usage would be more responsible and respectful of school rules as they moved closer towards the close of the academic school year.

Challenges

The transition back to school in person during the early part Fiscal Year 21-22 was hopeful. Once school started it was quite evident that the challenges being felt were widespread in the YMCA, in the schools, and in the community. Caseloads were reported being filled within the first month of school, which would take two to three months in the past. Referrals were high and the needs of the students were much higher. The waves of COVID surges that continued for most of the school year not only taxed students returning to campus for the first time in person in over 18 months but taxed the school as well.

The beginning of the year was incredibly chaotic, as school admins were overwhelmed with the challenges of managing contact tracing and staff shortages. The first couple of months were difficult as multiple staff and students had long absences due to the pandemic. There was also a high level of

anxiety as everyone worked to adjust to being back on campus. COVID precautions in place to ensure the safety of all staff and students on campus also put restrictions on how many students could gather in an enclosed space at one time. The YMCA provided SSAs with air purifiers and personal protective equipment (PPE) to ensure that spaces where services were being provided offered as much protection as possible to both staff and students. The number of students able to attend a group at one time was limited to four. Smaller group sizes impacted the numbers of students served.

During FY 2021-22, the YMCA experienced staff turnover with the two high school SSAs. The SSA at South San Francisco high school left the position and provided ample notice and finished out the school year. The SSA at El Camino left the position in March with two weeks' notice. Not having an SSA on campus meant that students were not able to engage in YMCA services and new referrals be absorbed by the school counseling team. This transition impacted the program overall, and halted referrals.

The number of referrals to the SSA for students caught using substances was very low. The number of students referred to the Alternative to Suspension (ATS) program for substance use has indicated otherwise. The ATS program is facilitated by YMCA staff in partnership with the school district. There has been some confusion on campus about what interventions will be utilized for students caught using substances. The YMCA has explicitly shared the First Stop group using MBSAT curriculum is a contracted group, and the hope is to close the gap with any students referred to the (ATS) program that are suspended for substance use as well. The expectation is these efforts will create a referral path to support any students that are caught using substances on campus and/or suspended for substance use.

The YMCA was able to hire a trainee in April that was already in a full-time trainee practicum placement elsewhere and looking for extra hours. That trainee was able to take on only half of the regular YMCA SSA position hours each week at El Camino. Challenges arose with onboarding delays with the YMCA, access to email, EHR, and required time for training. Challenges with the school district resulting in no access to district email and school database. Those challenges coupled with continued COVID outbreaks severely impacted the numbers of clients served in the program for the remainder of the school year. The positive note is that the hired staff will remain at El Camino high school this year and continue in the SSA role.

Specific challenges related to outcome data and reporting are related the learning curve associated with the transition to a new EHR and creating reports, adding fields to capture specific data that has not been captured before, and IT support needed to make the changes. Some challenges with the YMCA high school SSA program are due to the range of ages of the high school students that are served. High school SSA services are provided through a school-based setting and referrals often don't extend beyond clinic or other outpatient services. Students engaging in substance use can most often be best served on campus by the SSA using the MBSAT curriculum. With a clear description of the data requirements moving forward, all the efforts will be made to create the reports.

PANCHE BE YOUTH PROJECT

The Latino Commission is the one agency out of the Trauma-Informed Co-Occurring Service for Youth strategy that proposed an alternate culturally relevant intervention/curriculum, The Panche Be Youth Project. The services will still consist of three required components; Group-Based Intervention; Community Engagement; and Social Determinants of Health (SDOH) Screening and Referrals.

The Panche Be Youth Project, which combines El Joven Noble, and Xinachtli programs delivered as an afterschool activity. The Xinachtli program assists teen girls in maintaining self-esteem, self-image and self-confidence to continue on to higher education. It is based on indigenous principals, and provides dialectic process designed to support and build on the strengths of the individual. It incorporates an educational and organizing process in the development of leadership capacity and personal community responsibility encouraging them to serve as guides for other young women in the community. El Joven Noble program incorporates social-cognitive behavioral skills building activities with culturally sensitive video clips, games, brainstorming, role playing to create group cohesion. The goal is to help prevent young men from participating in gangs, reduce crime, increase numbers of youth attending college, improve prevention and health knowledge.

The Latino Commission will provide two cohorts of group-based interventions per year to an average of eight youth per cohort in North County and Halfmoon Bay. One additional session will be conducted in collaboration with BHRS to present on youth community engagement opportunities. As of this reporting year, The Latino Commission had not started groups due to the COVID-19 pandemic challenges but, have since started providing services virtually, outcomes will be reported in the next Annual Update.

TEACHING PRO-SOCIAL SKILLS

This program was inadvertently kept on the MHSA roster. Beginning FY 2020-21, Human Services Agency decided to no longer provide the Teaching Pro-Social Skills (TPS) evidence-based training program. The program will be rolled into the larger Trauma-Informed Co-Occurring Services for Youth strategy, described in the following section for the next Request for Proposal (RFP) process to allow agencies to propose culturally responsive evidence-based and/or community defined best practices.

HEALTH AMBASSADOR PROGRAM - YOUTH (HAP-Y)

The Health Ambassador Program for Youth (HAP-Y) engages youth (ages 16-24) in trainings, conversations, and workshops around mental health and wellness. The goal of the program is for participants to become mental health agents in their communities and work to reduce stigma through mental health awareness presentations and resource sharing. To prepare youth to support

their peers, youth participate in an extensive 14-week training program where they learn about the following topics/workshops:

- Question, Persuade, Refer (QPR)
- LivingWorks Start
- Wellness Recovery Action Plan (WRAP)
- Anxiety
- Substance Use
- Mood and Personality Disorders
- Lived Experience Guest Speaker/s
- Consent and Healthy Relationships
- Intro to Mental Health and Stigma
- Brain Development and Medications
- Trauma and Anxiety Disorders

As a way to encourage youth to actively advocate for mental health and wellness, participants are required to participate in three community involvement activities in which they educate their peers, share resources, and disclose their lived experience (when appropriate).

Program Impact

HAP-Y*	FY 2021-22
Clients served (unduplicated)	31
Cost per client	$8,065
Individuals reached (duplicated)	143
Total Served	174

** Unduplicated clients served are the youth Health Ambassadors, individuals reached includes the broader community receiving training, education from the ambassadors.*

Outcome Indicators

Domain	Indicators/Questions	#	%
Self-Empowerment	Participating in HAP-Y, led me to consider a career in mental health-related field (cohort)	13	65%
Stigma Reduction	I feel comfortable discussing topics related to mental health. (Cohort)	14 48	70% 67%

	I feel comfortable discussing topics related to mental health. (Audience) I feel comfortable seeking mental health services (Audience)	36	60%
Knowledge & Access to services	I know who to call or access online if I need mental health services.	53	74%
Community Advocacy	After participating in HAP-Y, I am able to contribute to other people's learning about mental health.	16	80%
Improve Knowledge, skills and/or abilities	HAP-Y provided me with knowledge and skills that I continue to use.	19	95%

***The development and implementation of the PEI Reporting Frameworks occurred late in the reporting period, so the data is not representative of the full reporting period.

Demographics

HAP-Y has not collected demographic data for audience members who experienced HAP-Y presentations; starting with summer cohort, audience surveys will be updated so that it instructs audience members to share demographic information.

Age (N=30)	**%**	**Sex assigned at birth**	**%**
Age 16-25	100.00%	Female	83.33%
Primary language	**%**	Male	16.67%
English	100.00%	**Gender Identity**	**%**
Race	**%**	Female/Woman/Cisgender Woman	50.00%
Asian/Asian American	50.00%	Male/Man/Cisgender Man	13.33%
Black/African American	6.67%	Genderqueer/Gender nonconforming	6.67%
Hispanic/Latinx/a/o	30.00%	Questioning or unsure	6.67%
Native American/ Indigenous	3.33%	Another	13.33%
Native Hawaiian/Pacific Islander	3.33%	**Sexual Orientation**	**%**
White/Caucasian	23.33%	Asexual	6.67%
Decline to State	3.33%	Bisexual	6.67%
Ethnicity	**%**	Gay or Lesbian	6.67%
Asian Indian/South Asian	10.00%	Straight or Heterosexual	43.33%

Chinese	20.00%	Indigenous sexual orientation	0.00%
Central American	10.00%	Pansexual	6.67%
Eastern European	3.33%	Queer	0.00%
European	6.67%	Questioning or unsure	6.67%
Filipinx/a/o	13.33%	Another	3.33%
Mexican/Chicanx/a/o	13.33%	Decline to State	3.33%
Puerto Rican	3.33%	**City/Region**	**%**
Vietnamese	3.33%	Pacifica	3.33%
Another	13.33%	Foster City	6.67%
Decline to State	3.33%	San Bruno	6.67%
Disability/Learning Difficulty	**%**	Redwood City	26.67%
Chronic health condition	6.67%	San Mateo	23.33%
Difficulty seeing	6.67%	Daly City	16.67%
Another	6.67%	Burlingame	6.67%
Decline to State	3.33%	Millbrae	6.67%
No	73.33%	South San Francisco	3.33%

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals	1	0	1
Substance Use Disorders (SUD) Referrals	0	0	0
Other Mental Health (MH) Referrals	4	0	4
TOTAL	**5**	**0**	**5**

Referrals to Other Services

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	0	Legal	0
Financial/ Employment	0	Medical care	0
Food	0	Transportation	0
Form assistance	0	Health Insurance	0
Housing/ Shelter	0	Cultural, non-traditional care	0
Other	0	**TOTAL**	**0**

Program Narrative

To ensure that this program is accessible to youth in different parts of the county, pre pandemic, each training program was hosted in different parts of the county. To continue to make this program accessible to youth throughout San Mateo County, the program was offered virtually for the FY 2021-22; hosting virtual programming has reduced the transportation challenge that youth may experience.

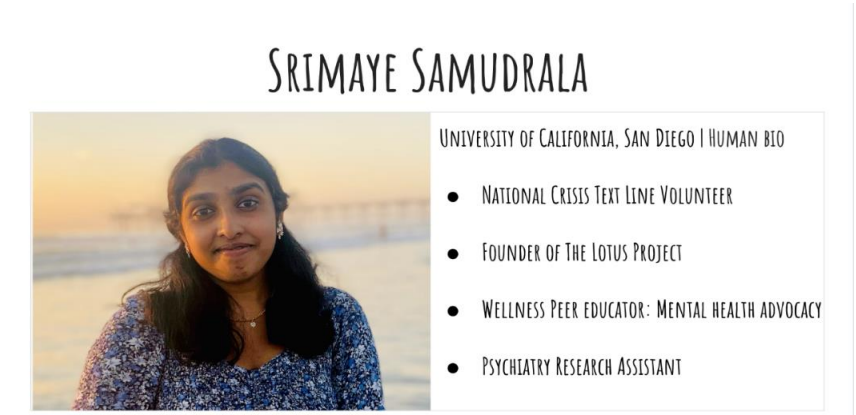
Programming has a big focus in acknowledging and addressing stigma that is attached to topics of mental health conditions and support-seeking, conversation and training offered to HAP-Y participants bring awareness and education. Along with the education and awareness, participants are introduced to a variety of services available to foster mental and overall wellness.

HAP-Y has been effective in providing its participants a safe space for youth to open up about their lived experiences and connect with others who have similar experiences or who can empathize with their experiences. 80 percent of the participants who successfully completed program in 21-22 said that participating in HAP-Y made them feel they were part of a community and, that same percentage, strongly agreed that HAP-Y has positively impacted their lives.

Successes

Health Ambassador Program for Youth has a wonderful fiscal year and continued to engage youth in meaningful and enriching conversations. HAP-Y is unique in attracting resilient, compassionate, and ideally to be part of conversation. A successful and inspiring is that of Srimaye.

Client Story: For the first time since HAP-Y started, the program had a former youth participant return to teach a workshop to latest cohort. Srimaye Samudrala went through HAP-Y programming summer of 2020, before they went to San Diego to attend college. After participating in HAP-Y training program, they were truly inspired to continue their work and advocacy for mental health wellness. With the support and guidance of their school professors and StarVista staff, Srimaye founded the Lotus Project- an initiative to help start positive conversation about mental health and wellness to high school and middle school students. The goal of the program is to reduce the stigma attached to these topics, so that youth can start seeking support earlier to prevent serious mental health challenges. The Lotus Project was inspired by HAP-Y and the knowledge and skill Srimaye gained throughout HAP-Y programming. In June 2022, Srimaye presented at HAP-Y on the challenges and successes they faced in doing advocacy work beyond HAP-Y. Srimaye's commitment, passion, and advocacy truly embodies the impact that HAP-Y has on participants long after their participation in HAP-Y has concluded.



HAP-Y has been able to provide a safe space and community for youth who are brought to the program by their own lived experience and, come to programming because they have had to support their loved ones/friends through some of the hardest times of their lives. These participants know, first-hand, about the stigma and stereotypes that so often are associated with folks who have mental health conditions. HAP-Y has been especially successful in achieving its goal of educating and bringing awareness around behavioral health to youth who don't identify as having lived experience. A perfect example is a youth who recently completed HAP-Y's training program. During the final workshop of the training, Photovoice Workshop, the participants were hesitant to share their story because they hadn't personally, experienced a mental health challenge. After checking in with HAP-Y staff and taking some time to reflect, their final photovoice project highlighted their overall experience with HAP-Y, and, as it turns out, what they learned through their HAP-Y experience they were able to apply to become a powerful ally and advocate for mental health. Their final photovoice is shared below. Its youth like BP who HAP-Y has the strongest and lasting imprint on.

I can

"Tell me and I forget, teach me and I may remember, involve me and I learn." Benjamin Franklin said that. For a long time, depressed people scared me. I was told how to support those people, told to be open, and approachable. Later on, I was taught ways to give support, and where to go if I needed it. However, I never got involved with the mental health crisis in America, and never truly learned how to help, and how to implement the strategies I was taught. That is why I joined HAP-Y. That, and my interest in how the brain works, what has to happen for someone to descend so rapidly down into the abyss of depression. HAP-Y has taught me how to give people support, regardless of if they are in a mental health crisis. I have learned how to be more approachable, and how to approach someone who is having difficulty approaching others. I have learned about the numerous mental health support resources available, and that it is possible for even the most hurt people to heal. I have also been able to develop strategies to help myself, when I notice myself spiraling, or getting triggered. HAP-Y is extremely helpful in teaching and involving those who are passionate about mental health, leveling them up, and inspiring them to advocate for and support mental health awareness. I leave you with this message: No matter how scary the feature looks, or how many things have gone wrong, you can always recover. It might not happen the first time, or even the fifth. But you have the power and the voice to stand up for yourself and live the life you want to live. - BP, 16

Challenges

At the beginning of the fiscal year, HAP-Y experienced a low number in youth participation for each cohort. HAP-Y staff have been able to address this challenge by hiring a part-time Youth Outreach Ambassador whose main role has been to support recruitment and outreach efforts. Since then, there has been a drastic increase in youth interest and participation; latest cohort started with 19 participants in comparison to the previous cohort in which only 6 youth participated in programming. The number of community presentations has decreased since the on-set of the pandemic. While HAP-Y does not have data to support this, HAP-Y participants have expressed that social isolation and distance learning has drastically increased their anxiety around public speaking and socializing. Being mindful of this, HAP-Y staff have been more flexible when it comes to community involvement activities. HAP-Y staff have tried their best to be mindful of this and flexible to having youth complete community involvement activities in other ways.

The process for referral tracking is something that HAP-Y staff will need to re-think; currently, it has been possible to track referrals that audience members have requested through the audience surveys. However, tracking referrals made by Health Ambassador's in informal interactions, during presentations, community events, and outside of HAP-Y related interactions, have not been tracked. As referrals have newly been identified as an item to be reported on, for the upcoming fiscal year, HAP-Y staff will implement a new procedure for tracking referrals on a monthly basis.

The last item to be mentioned is, both, a success, and a challenge, nonetheless, need to be mentioned. StarVista has experienced a lot of transitions as an organization. During the last year, many changes happened with leadership; including the Department Director that was overseeing HAP-Y. Other changes that have occurred include HAP-Y direct staff; HAP-Y Program Coordinator was promoted to Program Manager. While the search and recruitment for the right candidate to take on the role of Program Coordinator has been a challenge, HAP-Y programming has continued to successfully meet its goal.

TRAUMA INFORMED 0-5 SYSTEMS

Acknowledgement of the lasting impact of adverse childhood experiences and movement towards providing trauma-informed care has been building for the last decade or more. It is now reaching a tipping point, with many leaders and practitioners from across sectors, including health, education, social welfare, housing, criminal justice, and others, recognizing that their clients and staff are experiencing or encountering trauma regularly. State funding and prioritization of trauma-related work is evident in the passage of Assembly Bill 340 in 2017 to mandate trauma screening for children on Medi-Cal, and the appointment of Dr. Nadine Burke-Harris, a pioneer in childhood trauma work, as the first California Surgeon General. There is tremendous energy and interest around trauma-informed practices locally.

With funding support from MHSA as well as additional support from Sequoia Healthcare District, First 5 San Mateo County (F5SMC) has launched a multi-sector initiative to transform service delivery for young children and their families. The Trauma- and Resiliency-Informed Systems Initiative (TRISI) is a countywide effort to integrate a comprehensive commitment to address trauma and promote resiliency into local programs, structures, and culture with a long-term goal of embedding trauma- and resiliency-informed policies and practices at every level of the system.

The strategies and targets for the Initiative include:

- Training and support for child- and family-serving organizations to imbed trauma-informed practices in their internal operations,
- Training and resources on trauma-informed practices for professionals working with children and families, and
- Education for parents to help recognize the signs and symptoms of trauma

Through an extensive planning process with cross-sector partners, the Initiative has established the following areas of focus:

- Systems Strengthening: Focused on system leaders, organizational leaders, policymakers
    - Activities include:
        - Coordination with other local, regional, and statewide efforts
        - Promoting common language/ approach
        - Policy and resource advocacy
- Practice Improvement: Focused on organizational leaders, managers, all staff
    - Activities include:
        - Online trauma and resilience resources
        - Trauma trainings and learning cohorts

    - Trauma-informed organization assessment support
    - Trauma-informed organization implementation support
- Initiative Evaluation: To measure if organizations have become more trauma- and resiliency-informed based on the Trauma-Informed Organizations Developmental Framework.

Progress to date includes:

1. *Online Resource Hub*: Development of a local online resource hub targeted at providers and other interested community members.
2. *Market Assessment Survey*: Creation, dissemination, and analysis of an online Market Assessment Survey designed to gauge the interest of local stakeholders in family-serving organizations in trauma-informed training and stages of organizational readiness.
3. *Countywide Trauma Convening*: Hosting of a full-day Culture of Care Convening focused on supporting trauma-informed organizational practices for child- and family-serving organizations attended by over 150 individuals and 40+ agencies
4. *Organizational Assessment Tool**: Identification of an organizational assessment tool to determine stages of readiness and areas for growth for child- and family-focused organizations interested in furthering their Trauma-Informed Organizational (TIO) practices; outreach/ education to publicize the tool; linkage and support for completing the tool and disseminating results internally
5. *Trauma-Informed Organization Cohorts and Coaching*:* Support the deepening of TIO practices for organizations by offering ongoing training, support, and action plans through group work in cohorts and specific agency-focused goals through coaching

*Activities have taken place within the current funding term.

Program Impact

Trauma-Informed 0-5 Systems	FY 2021-22
Total clients served	346
Total cost per client	$434

For the purposes of the report, the “clients” served are, most directly, the staff and providers working within the target agencies that serve children and families in San Mateo County. In this context, the MHSA Intended Outcomes would be sought for providers within the community who work to serve the public. While the TIO Assessment Tool does not ask particular questions about the mental health status or outcomes for agency staff, the overarching intention of building a community of trauma-informed organizations is consistent with supporting positive mental health practices and outcomes for staff of child and family serving organizations.

To this end, the data gathered from 346 staff participants within seven of the eight agencies that completed the TIO Assessment Tool for TRISI 1.0 and the subsequent analysis in the previous fiscal year is included again here as TRISI 1.0 TIO Assessment Data Report.

The aggregate level TIO Assessment data for the three new participating agencies for TRISI 2.0 will be collected during FY 2022-23 and will therefore be shared in a following report.

Successes

TRISI 1.0 Cohorts and Coaching: As a reminder, two TIO cohorts commenced in May of 2021 with six agencies participating and 26 individual participants initially in total. Over the course of the 8-month cohort duration, the number of participants shifted to 23 due to attrition, primarily caused by staff leaving their positions within their agencies. The cohorts ran monthly through January of 2022 and then moved to a quarterly format for the remainder of 2022, meeting once more during the FY 2021-22. The individual agency-level coaching was offered once a month to all six participating agencies through the entirety of the fiscal year.

In December 2021, the TRISI Core Team conducted an online survey of participants and elicited feedback during the cohort sessions to capture successes and challenges. A summary of this evaluation is attached to this report as TRISI 2021 Evaluation Summary.

TRISI 2.0 Planning and Design: The major success of this portion of the Initiative during this fiscal year was the collective commitment to pursuing a second round of TRISI assessment, cohorts, and coaching supports for three of the largest public children- and family-serving agencies in San Mateo County. The prioritization by agency leaders to engage their staff in a process to support the ongoing pursuit of more trauma-informed organizational practices is a profound one in and of itself. Additionally, all TRISI Core Team consultants and leads of the work signaled their commitment to a second round of this model and signed on to contracts to continue this work through June 2023.

In order to move this effort forward, additional funding was committed from MHSA and approved by the SMC Board of Supervisors in the Spring of 2022, which then allowed for First 5 SMC to channel those dollars, along with braided funding from First 5 and other funders into the revised contracts noted above for three of four consultant entities. The fourth of these contract agreements is slated for review and approval in Fall 2022.

In Q4 of FY 2021-22, the TRISI Core Team worked diligently to draft the design, roles, and timeline for TRISI 2.0 and to bring this to agency leaders for their input. The work of this team included integrating feedback from TRISI 1.0, rethinking the design to adapt to the anticipated needs of large public bureaucracies, and integrating a new cohort facilitator into the role.

Challenges

TRISI 1.0 Cohorts and Coaching: As noted in the previous section, a summary of the challenges and successes of this work through December 2021 is attached to this report. Please see the TRISI 2021 Evaluation Summary for details.

1. TRISI 2.0 Planning and Design: Although leadership from the three TRISI 2.0 organizations have been in conversation with the TRISI Core Team beginning to formulate plans for partnership since November of 2021, several factors prolonged the active planning between Core Team and 2.0 agencies.
2. Contracting: The contracting process to align funds for the work had several steps (funder to First 5, First 5 to consultants) that required approval from formal bodies such as boards or commissions. These contracts were foundational for all parties to be able to commit to the process and time required for this work.
3. Cohort Facilitator: In February, the consultant who had held the role of cohort facilitator for the TRISI 1.0 work transitioned out of her role, leaving a critical vacancy that wasn't filled until June 1. Although the gap in this role didn't delay the overall planning, certain decisions about the cohort structure, design, and content needed to wait for her input. The TRISI Core Team is happy to have Dr. Tasha Parker from Institute of Development serving this function through FY 2022-23.
4. Availability: Aligning calendars for all Core Team members and TRISI 2.0 leaders in the beginning phase of this work was challenging as schedules were tight all around. This challenge has lessened over time as standard meeting times were set and additional meetings were planned out further in advance.

PEI AGES 0-25: EARLY CRISIS INTERVENTIONS

YOUTH CRISIS RESPONSE & PREVENTION

The Youth Stabilization, Opportunity, and Support (S.O.S) Team provides over the phone or in-person response to youth ages 0-25 living in San Mateo County that are experiencing an escalation in mental health symptoms. Symptoms may range from suicidal ideation to undiagnosed mental health disorders. The Youth S.O.S team, made up of mental health clinicians and family partners, provides comprehensive address suicide and crisis assessment, psychoeducation, brief individual counseling, and case management needs. In addition to responding to families in crisis, the Youth S.O.S team also provides San Mateo County schools assistance with suicide assessments and/or crisis intervention.

This program prioritizes the needs of marginalized youth that have experienced abuse, are currently or have formerly been in foster care, experienced unstable housing/homelessness as well as youth

that belong to the LGBTQ+ community. The Youth S.O.S Team is also responsible for in-person mobile crisis response for the California Family Urgent Response System (CAL-FURS). The CAL-FURS program is in place to support current and former foster youth as well as their caregivers when crisis occurs. The CAL-FURS program "FURS is a coordinated statewide, regional, and county-level system designed to provide collaborative and timely state-level phone-based response and county-level in-home, in-person mobile response during situations of instability, to preserve the relationship of the caregiver and the child or youth."

The overall goals of the Youth Stabilization Opportunity and Support (Youth S.O.S.) team is to decrease youth psychiatric emergency service visits, decrease hospitalization for self-harm, decrease emergency calls to law enforcement for youth in crisis, and improve family/caregivers' ability to navigate crisis and increase access of emergency crisis services. As the mobile responders for CAL-FURS, the team's goal also strives to maintain and support stability of youth in foster care placement and improve trust between youth and caregivers.

Program Impact

Youth SOS*	FY 2021-22
Clients served (unduplicated)	37
Cost per client	$22,082
Individuals reached (duplicated)	72
Total Served	109

** Unduplicated clients served are youth served by the mobile crisis response, individuals reached includes the family members or caregivers of youth served and/or individuals reached through outreach/education.*

Outcome Indicators

Domain	Indicators/Questions	#	%
Improved knowledge, skills, and/or ability	*Number of youths who learned a new coping strategy to increase mental, emotional, and relational functioning.*	37	100%
Connection and Support	*Number of youths who can identify and feel safe reaching out and contacting at least one adult when they are experiencing emotional distress during a follow up session.*	34	92%
Self-Empowerment	Number of youths who can identify and feel confident accessing emergency mental health services when their emotional distress is high.	33	91%

Knowledge & Access to Services	Number of caregivers or family members who received psychoeducation and resources to increase youth's community and relational support. Population= family members/caregivers of youth)	35	100%
Utilization of Emergency Services	Youth Diverted from use of psychiatric emergency services) population- youth who received Youth SOS services) Youth that did not require law enforcement intervention (population- youth SOS services)	37 37	100% 100%

Demographics

StarVista was unable to obtain adequate demographic information on family/caregivers. Upon initial planning, the youth mobile crisis response team had planned to collect this data during mobile crisis response. The number of in person responses was lower than anticipated, and a higher number of telephones only responses occurred. The assumption of where to best collect this data was incorrect. As a result, a higher number of demographic information for caregivers was missed and the required fields at the start of a telephone response has changed and clinicians/family partners will not be required to collect caregiver information over the phone and prior to telephone response. Clinicians will be required to ensure that demographic graphic information is not just collected for in person response, but also when providing over the phone support through means of consultation.

Age (N=35)	**%**	**City/Region**	**%**
Age 0-15	66%	Pacifica	9%
Age 16-25	34%	San Carlos	11%
Primary language	**%**	San Bruno	6%
English	91%	Redwood City	9%
Spanish	9%	San Mateo	23%
Race	**%**	Daly City	20%
Asian/Asian American	3%	Santa Clara	6%
Black/African American	3%	San Jose	3%
Hispanic/Latinx/a/o	20%	South San Francisco	9%
Middle Eastern	3 %	Menlo Park	3%
White/Caucasian	20%		
Decline to State	51%		
Gender Identity	**%**	**Sexual Orientation**	**%**
Female/Woman/Cisgender Woman	26%	Straight or Heterosexual	14%
Male/Man/Cisgender Man	40%	N/A/Don't Know	63%

Transgender Male/Trans Man	3%
N/A/Don't Know	26%
Nonbinary/Genderqueer	3%

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals	0	0	0
Substance Use Disorders (SUD) Referrals	1	0	1
Other Mental Health (MH) Referrals	0	3	3
TOTAL	**1**	**3**	**4**

Referrals to Other Services

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	0	Legal	0
Financial/ Employment	0	Medical care	0
Food	0	Transportation	0
Form assistance	0	Health Insurance	0
Housing/ Shelter	0	Cultural, non-traditional care	0
Other	3*	**TOTAL**	**3**

**All 3 "Other" referrals where to a school counselor*

Program Narrative

The Youth S.O.S. team provides telephone de-escalation or in person response to youth and families in crisis, and until all concerns have been addressed by providing trauma informed de-escalation strategies. Clinicians will assess for higher level interventions at the time of initial crisis and will also provide follow-up care as needed/requested by the youth or families. The multi-disciplinary team will provide appropriate resources to the youth and family at the time of response and through follow-up, which may include:

- Linkage to existing services
- Coordination with physician and/or psychiatrist
- Basic needs assessment
- Other community supports

These interventions will support awareness and knowledge of services to underserved population and will support families in better understanding and obtaining access to public health services.

Successes

A concerned father called StarVista' s Crisis Line and requested Youth S.O.S services after witnessing his son extreme emotional dysregulation due to cannabis withdrawal. The father shared that he supports his son in his decision to reduce his use of cannabis but expressed worry for his son's safety after witnessing extreme symptoms of anxiety and distress throughout the withdrawal process. The Youth S.O.S team provided multiple in-person responses to the family and assisted youth with on-going daily support as he transitioned away from substances. The Youth S.O.S. clinician also provided brief/short term services to the family. The Youth S.O.S clinician referred the family to another StarVista program, Insights, so that the son could receive substance use treatment.

A concerned mother and father called the StarVista Crisis Line and requested Youth S.O.S. services after their 7-year-old shared his thoughts of suicide. This youth struggled with managing his time at home, and frequently became very dysregulated and unable to manage feelings when asked to transition between activities. This concerned mother and father struggled to understand their son's discomfort with transition and shared they felt hopeless and exhausted by managing his "extreme reactions to change." The Youth S.O.S team provided numerous in person response to assist these caregivers with supporting their son through transition and provided a referral to Therapeutic Behavioral Services (TBS) through Fred Finch Services. The family was connected to services and was able to receive access to long term support for their son.

Challenges

This program faced numerous challenges regarding hiring and recruitment of Youth S.O.S mental health clinicians. As a result, the hours of operation were extremely limited at launch. This program became fully staffed in March 2022 and has been fully operational since. Moving forward, this program's goal is to focus on staff retention to maintain full 24/7 coverage of this Youth S.O.S team.

By design, this program's main purpose is to provide in-person mobile crisis response to youth and families in crisis. However, the data from this year shows a higher demand for telephone only response. This may be due to a caller's request to seek information only about Youth S.O.S. services in order to prepare for future use, as well as concerns /hesitation about in-person services due to on-going covid-19 concerns.

As a result, the ability to provide referrals and case management services has been limited. Initially, the intention was to provide a family needs assessment upon initial in-person response. Due to the higher volume of telephone only responses, clinicians will now ask families if they would like an additional (telephone only) follow up call from a family partner. This will be an opportunity for families to further explore what public health services are available to serve their needs. It is the hope to increase opportunities for family partners to engage with families in a basic needs assessment and provide resources to assist and prevent families from future crisis.

OFFICE OF DIVERSITY AND EQUITY (ODE)

The Mental Health Services Act provided dedicated funding to address cultural competence and access to mental health services for underserved communities; in San Mateo County this led to the formal establishment of the Office of Diversity and Equity (ODE) in 2009. ODE advances health equity in behavioral health outcomes of marginalized communities. Demonstrating a commitment to understanding and addressing how health disparities, health inequities, and stigma impact an individual's ability to access and receive behavioral health and recovery services, ODE works to promote cultural humility and inclusion within the County's behavioral health service system and in partnerships with communities through the following programs:

- Health Equity Initiatives
- Health Ambassador Program
- Adult Mental Health First Aid
- Digital Storytelling and Photovoice
- Stigma Free San Mateo – Be the ONE Campaign
- San Mateo County Suicide Prevention Committee (SPC)

Program Impact

The Office of Diversity and Equity measures progress along 5 indicators. These definitions are influenced by (1) public health frameworks and (3) ODE's mission, values and strategy.

- Self-Empowerment – enhanced sense of control and ownership of the decisions that affect one's life
- Community Advocacy – Increased ability of the community to influence decisions and practices of a behavioral health system that affect their community
- Cultural Humility – heightened self-awareness of community members' culture impacting their behavioral health outcomes; heightened responsiveness of behavioral health programs and services for diverse cultural communities serve
- Access to Treatment/Prevention Programs (Reducing Barriers) - enhanced knowledge, skills and ability to navigate and access behavioral health treatment and prevention programs despite potential financial, administrative, social and cultural barriers.
- Stigma Discrimination Reduction - reduced prejudice and discrimination against those with mental health and substance use conditions.

ODE (Across all programs)	FY 2021-22
Individuals reached (duplicated)	5585

** Unable to report unduplicated clients served as a whole; some programs are tertiary prevention focused on broad community awareness and/or system change*

Outcome Indicators

Domain	Indicators/Questions	#	%
Cultural Humility	As a result of this training, I have a better understanding of how mental health and substance use challenges affects different cultures. (agreed/strongly agreed)	110	89%
	Acknowledging that the Adult Mental Health First Aid (AMHFA) course was culturally relevant to most participants. (agreed/strongly agreed)	110	88%
Stigma Reduction	Feel confident that they can reach out to a person who may be dealing with a mental health problem, substance use challenge or crisis.	110	100%
	Feel confident they can recognize and correct misconceptions about mental health, substance use and mental illness as I encounter them.	110	100%
	Have learned MORE about mental health and/or substance use services that I can reach out to, as a direct result of this program. (agreed/strongly agreed)	68	90%
	Are MORE willing to seek professional support for a mental health and/or substance use condition if I need it a direct result of this program. (agreed/strongly agreed)	68	87%
Self-Empowerment	Satisfied with their parenting skills	110	94%
	Feel overall satisfied with the relationship with their child	110	100%
	Feel supported as a parent	110	94%
	Fewer difficulties relating to communication with their child (89% at pre to 56% at post)	110	56%
Access to Services	Feel that they strongly agree or agree that they are more willing to seek support from a mental health professional if they think they need it. (agreed/strongly agreed)	68	100%

	Program was relevant to me and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc.). (agreed/strongly agreed)	68	94%

2022 Mental Health Month (MHM) statewide theme was Take Action for Mental Health. The campaign goal was to offer community mental wellness tools to seek help for themselves or a loved one. Some survey respondents completed the following sentence as follows, "As a result of this program, I will Take Action for Mental Health by..."

- "Looking into finding a WRAP group immediately"
- "Find a support group"
- "Telling people about the resources in our county"
- "Encourage my family members to seek mental health support and destigmatize therapy and other mental help resources."
- "Reaching out to professionals"
- "Getting in touch with my therapist"
- "Continuing to participate in WRAP groups"
- "Seeking out a therapist and getting help"
- "Working to help my friends access mental health resources"

Demographics

Demographic surveys were collected from individual served across ODE programs.

	FY 2021-22		FY 2021-22
Age	**%**	**Sex assigned at birth**	**%**
Age 0-15	2%	Male	27%
Age 16-25	11%	Female	62%
26-59	70%	Decline to state	0%
60+	18%	**Sexual Orientation**	**%**
decline to state	10	Gay or Lesbian	10%
Primary language	**%**	Straight or Heterosexual	68%
English	88%	Queer	9%
Spanish	6.78%	Decline to State	9%
Mandarin	1%	Another sexual orientation	5%
Tagalog	1%	**Gender Identity**	**%**
Decline to State	4.08%	Male/Man/ Cisgender	27%
Bilingual	0%	Female/ Woman/ Cisgender Woman	62%
Another language	5.08%	Transgender Male	0%

Race/Ethnicity	%		
American Indian/ Alaska Native/ Indigenous	4%	Transgender Woman	0%
		Genderqueer/ Nonconforming	6%
Asian	29%	Indigenous gender identity	0%
Black/ African- American	5.1%	Another gender identity	1%
White/ Caucasian	26%	Decline to state	1%
Hispanic/ Latinx	29%		
Native Hawaiian	2%		
Another race/ ethnicity	2%		
Decline to state	5.1%		

HEALTH EQUITY INITIATIVES (HEI)

The Health Equity Initiatives (HEI) address access and quality of care issues among underserved, unserved, and inappropriately served communities. ODE provides oversight to nine HEIs representing specific ethnic and cultural communities that have been historically marginalized: African American Community Initiative, Chinese Health Initiative, Filipino Mental Health Initiative, Latino Collaborative, Native and Indigenous Peoples Initiative, Pacific Islander Initiative, PRIDE Initiative, Spirituality Initiative, and the Diversity and Equity Council. HEIs are comprised of San Mateo Behavioral Health and Recovery Services staff, community-based health and social service agencies, partners from other County agencies, clients and their family members, and community members. HEIs are typically managed by two co-chairs, including BHRS staff and/or a community agency or leader.

HEIs implement activities throughout San Mateo County that are intended to:

1. Decrease stigma
2. Educate and empower community members
3. Support wellness and recovery
4. Build culturally responsive services

Program Impact

Health Equity Initiatives	FY 2021-22
Individuals reached (duplicated)	5585
Total cost per client	$55

** Unable to report unduplicated clients; HEIs focused on broad community awareness and system change strategies (presentations, events and trainings).*

DIVERSITY AND EQUITY COUNCIL (DEC)

The Diversity and Equity Council (DEC) works to ensure that topics concerning diversity, health disparities, and health equity are reflected in the work of San Mateo County's mental health and substance use services. The formation of the DEC can be traced back to 1998 when staff members formed the Cultural Competence Committee. This committee later became the Cultural Competence Council in 2009, which played an integral role in the formation of ODE and meet the Department of Health Care Services' Cultural Competence Plan Requirements (per California Code of Regulations, Title 9, Section 1810.410).

Mission, Vision, & Objectives

The Council serves as an advisory board to assure BHRS policies are designed and implemented in a manner that strives to decrease health inequalities and increase access to services.

Highlights & Accomplishments

In FY 2021-22, the Diversity and Equity Council, supported Suicide Prevention Month by offering the Be Sensitive Be Brave for Suicide Prevention (BSBB) training for DEC members and community at large. This was a foundational workshop in suicide prevention to teach participants how to act as eyes and ears for suicidal distress and connect individuals with appropriate services. Workshop participants learned to recognize suicide risk, how to ask individuals if they are thinking about suicide and connect them with help. Secondly, the DEC successfully updated the DEC Strategic Plan, this included an extended retreat hosted in January to collect feedback and help prioritize DEC activities for the upcoming year. This was very helpful as the DEC is transitioning from COVID response work to more direct activities to advance health equity. The group identified three areas of focus including: serving as an advisory body for BHRS, continuing to be a space of collaboration for CBOs and HEIs, and a hub of information for San Mateo County communities at large. As part of the updated strategic plan, the DEC included a monthly "Spotlight" on the DEC agenda to provide an opportunity for DEC members to give a presentation about their organizations/programs to encourage networking and collaboration. They also created a member contact list, to encourage communication between members. The DEC also created a subgroup, the Cultural Competence Open Forum, to discuss cultural competence specific requirements, barriers, successes, and progress with members representing contracted agencies. DEC also supported 4 of the members representing community-based organizations, to participate in a training on Emerging Best Practices for Communities of Color, Prevention and Treatment Modalities that took place on Wed. February 16, 2022.

High participation and engagement have led to important conversations on how the DEC can continue to advance and encourage new members joining the initiative. In addition, the "Spotlight" presentations that began in April 2022, allowed members to present on their agencies, upcoming projects and supports needed from the initiative. The DEC has heard presentations from Project Sentinel on General Fair Housing Information, Health Plan of San Mateo and their Health Equity

Strategy, San Mateo County Pride Center Programs and Resources, California Clubhouse, and the San Mateo County Public Health Policy and Planning Community Collaboration Process. All these efforts have helped connect various programs and organizations in order to strengthen the community and the knowledge of resources available in San Mateo County.

AFRICAN-AMERICAN COMMUNITY INITIATIVE (AACI)

African American Community Initiative (AACI) efforts began in 2007 and were led by African American BHRS staff members committed to: increasing the number of African American clinicians working within BHRS; improving the cultural sensitivity of clinicians to better serve the African American community; and empowering African Americans to advocate for equality and access to mental health services. The AACI works towards these goals by providing support and information about mental health and recovery services to BHRS clients and residents.

Mission, Vision, and Objectives

The AACI has defined its vision as working to improve health outcomes and reduce health disparities for African Americans in San Mateo County and has identified the following objectives as necessary steps towards achieving this vision:

- Awareness: Increase overall community awareness and involvement of community members in African American Community Initiative
- Utilization/Access: Increase knowledge and utilization of mental health services of BHRS among African American community members in San Mateo County.
- Education/Training: Act as liaison between African American community and BHRS, assisting in linkage to services such as Black Infant Health and community trainings such as Mental Health First Aid, Photo Voice, and Applied Suicide Prevention.
- Employment: To advocate for the staffing of at least one African American clinician or peer-support provider (MFT, LCSW, and other providers) in each Community Service Areas of San Mateo County's Behavioral Health and Recovery Services.
- Research: To provide feedback and inform San Mateo County BHRS regarding African American community as result of surveying through the Office of Consumer Affairs, focus groups, and community-based research.
- Outreach: Conduct at least one annual community-based event, such as in celebration of Black History Month, Juneteenth, or Kwanzaa to build support of AACI and to reach out to the African American community.
- Partnership: Partner with other organizations and health equity initiatives from the Office of Diversity and Equity to support AACI and African American clients and professionals as well as other diverse groups; link and collaborate with other entities that work in various capacities with African American community members.

Highlights & Accomplishments

One of the goals of The African American Community Initiative is to increase collaborative efforts with other HEI's in order to identify the health needs of communities of color and ultimately decrease disparities for communities of color. Black History Month events in 2022 focused on Black History Month, "Black Health and Wellness", takes a look at how American healthcare has often underserved the African American community. Additionally, the AACI in collaboration with Voices of Recovery presented the Juneteenth Celebration : Freedom and Fatherhood. This event held great value to the community as it had various workshop opportunities such as the fatherhood panel, Discussion with the keynote speaker James Simmons. As the COVID-19 pandemic has recently shown, a widespread disparity of access to quality healthcare negatively impacts outcomes for blacks and other minorities. For African Americans, the root of the problem goes deep, and back centuries. It acknowledged the chronic stress of racism and that everyday family challenges (such as securing resources, family stability) can add even more stress. The Initiative offered workshops and activities that provided coping strategies for the whole family to mitigate stress. Participants remarked that the workshops and speakers were very helpful and meaningful. The event planning began in the annual AACI strategic planning.

In FY 2021-22 community members participated in and/or hosted the following AACI events:

- Black History Month Celebration
- Juneteenth Celebration- Freedom and Fatherhood
- Support the Intergenerational Conversation with the San Mateo PRIDE Center
- Umoja Health San Mateo County
- Information presentation – Social Ecological Determinants of Heath
- Tabling Opportunities

CHINESE HEALTH INITIATIVE (CHI)

The Chinese Health Initiative (CHI) efforts began in 2007 by San Mateo BHRS staff members who were committed to providing and advocating for culturally and linguistically accessible and responsive services within the San Mateo County Health System. By collaborating with partners, conducting community outreach, and providing service referrals, CHI members work to empower Chinese residents to seek services for mental health and substance use issues.

Mission, Vision, and Objectives

The Chinese Health Initiative works to improve engagement and utilization of BHRS mental health and substance use services among the Chinese community. In order to ensure the services Chinese clients, receive are culturally-sensitive and appropriate, CHI works to increase provider capacity to serve Chinese clients by advocating for the hiring of Chinese staff who are able to reflect the culture

and language needs of Chinese clients. Much of CHI's work is focused on reducing the stigma associated with seeking services for mental health issues and accessing care. Recognizing a need for targeted community outreach and engagement, CHI advocated and received funding for a Chinese Outreach Worker position which has since been funneled into a contract with an outside agency.

Highlights & Accomplishments

During the FY 2021-22 the Chinese Health Initiative (CHI) created public spaces where members of the community, BHRS staff and other residents could feel comfortable openly talking about issues they would normally prefer to talk about in a private setting, namely immigration and suicide. CHI was able to collaborate with many different organization, agencies, and county programs to provide education, information to CHI members. Partnership with Filipino Mental Health Initiative and the Pacific Islander Initiative helped us increase a commitment and understanding of common aspects of Asian, Asian American, or Pacific Islander (AAPI) identity, struggles, and solidarity. There was also increased collaboration with Self Help for the Elderly in order to better address the needs of monolingual Cantonese-speaking elders in San Mateo County.

In FY 2021-22 community members participated in and/or hosted the following CHI events:

- Sherry C Wang, PhD on AAPI Mental Health, COVID-19, and Racism
- Elaine Hsieh, PhD, RDN on Nutrition and Healthy Living for the Asian Elder Community
- Be Sensitive Be Brave Mental Health and Suicide Prevention Workshop for Chinese Mandarin-speaking communities
- Lung Cancer Prevention and Screening with Esther Chyan, RN
- Adult Mental Health First Aid
- Mills Mental Health Advancement Initiative Day
- Tabling Opportunities

FILIPINO MENTAL HEALTH INITIATIVE (FMHI)

The Filipino Mental Health Initiative (FMHI) began as an informal gathering of Filipino clinicians from BHRS North County Clinic and local community-based organizations with the intent to support and elevate the needs of Filipino families and provide mental health outreach and education. A series of focus groups were conducted in 2005 by San Mateo County BHRS. During these focus groups, community members, providers, and staff members discussed issues pertaining to mental health, stigma, and barriers to accessing care among Filipinos living in San Mateo County. Following these focus groups, in 2006 interested members formed a group with funds made available from MHSA to support Filipino families not yet connected to services. In 2010, FMHI was formally established as one of ODE's nine Health Equity Initiatives.

Mission, Vision, & Objectives

The FMHI seeks to improve the well-being of Filipinos in San Mateo County by reducing the stigma associated with mental health issues, increasing access to services, and empowering the community to advocate for their mental health. The FMHI works to connect individuals to appropriate health, mental health, and social services through community outreach and engagement. By collaborating and working with providers, the FMHI also works to ensure that culturally appropriate services are available to Filipino residents.

Highlights & Accomplishments

In FY 2021-22 the FMHI made efforts consisting of creating a community calendar where people could have access to outlets for social interaction and connection, as well as forming a bi-weekly support group (Kapwa Soul Sessions). This effort began in the fourth quarter of FY 2019-20 and FHMI was able to continue this through FY 2021-22. These efforts aimed to address community needs brought on by the pandemic, but also focused on pointing them to the resources and support in the community. In addition, FHMI made sure the themes of Kapwa Soul touched on current events that were intensifying stress levels. Other COVID-19 responses included collaborating with other Filipinx organizations to create spaces for community, in the form of an open mic, to address both the pandemic and racial injustices.

FHMI participated in the Filipinx Wellbeing Conference at San Francisco State University where Christi & Alaina co-facilitated workshop: (Re)membering Our Roots- this workshop is for registered youth 9th-12th graders interested in exploring Filipinx Identity. Topics that will be unpacked are family dynamics, Filipinx history and identity, knowledge of Self, and how to get help.

Overall, FMHI has worked creatively about how to continue engaging the community and keep them informed, especially among the older adult Filipinx population that does not always access information online. As a result, the initiative created a wellness outreach campaign called, the “Mano Po Project.” This included interfacing with elders and other vulnerable community members at places like one of the Daly City food bank distribution centers, where members volunteered to help hand out goods, while also providing important information about COVID-19 safety and mental health/wellness resources available in San Mateo County. These activities underscore the strengthening of FMHI’s approach to create activities that engage community members in a culturally-responsive manner with the goal of building a consistent network of members, partners and collaborators who have successfully been doing this work in the community.

In FY 2021-22, FMHI participated and/or hosted the following events and activities:

- SOULidarity Healing Circle
- Mental Health First Aid training
- Kapwa Soul Sessions between July 2021 to June 2022
- Youth Engagement/Sala Talks
- BRIDGE Advisory

- Saints and Sentinels/Mano Po Project
- Suicide Prevention Month Events
- Black History Month
- Equity Through Arts Series
- Filipinx Kwentuhan: Equity through Art Webinar
- Filipinx Wellbeing Conference at San Francisco State University: Remembering Our Roots

LATINO COLLABORATIVE

While the Latino Collaborative (LC) efforts began in 2008, its founding members have been committed to giving voice to the Latino community since the late 1980s. During these initial meetings, a small group of Latino providers met informally to address issues pertaining to health disparities and access within the Latino community and mental health services. These meetings continued and in 2004, a core group of Latino providers requested a Latino-specific training for providers. At the time the County did not have the funds to provide the requested training. As a result, Latino providers organized regular meetings for San Mateo BHRS providers to come together to discuss client cases and strategies for serving the Latino population.

Mission, Vision, & Objectives

The Latino Collaborative's mission includes critically exploring the social, cultural, and historical perspectives of Latino residents within San Mateo County. The Latino Collaborative gives a voice to the Latino community by working together to support mind, body, soul and healthcare practices that are culturally appropriate. The Latino Collaborative has defined its mission as:

- Creating stronger, safer, and more resilient families through holistic practices.
- Promoting stigma-free environments.
- Providing fair access to health and social services, independent of health insurance coverage.
- Appreciating and respecting traditional practices.
- Recognizing and incorporating Latino history, culture, and language into BHRS

Highlights & Accomplishments

In FY 2021-22 the Latino Collaborative welcomed several presenters sharing local resources into its meetings. Because most members have direct contact with the community via direct services or outreach and prevention, these informational presentations can impact services. Additionally, the LC continued its efforts to provide the community with resources through its LC members and handing out physical information in English and Spanish.

In FY 2021-22, the LC participated and/or hosted the following events and activities:

- Sana, Sana In-person event

- Dia de los Muertos
- National Day of Prayer
- Mental Health Advocacy for Spanish Support Groups via Faciliatory Trainings
- Caesar Chavez Day
- PRIDE Event 2022
- Immigrant Heritage Month
- Mental Health Awareness Month Events

NATIVE AND INDIGENOUS INITIATIVE (NIPI)

The Native and Indigenous Peoples Initiative (NIPI) is one of the newer Health Equity Initiatives, established in 2012. Inherent to their work is building appreciation and respect for Native American and indigenous history, culture, and spiritual healing practices.

Mission, Vision, & Objective

NIPI has defined its mission as generating a comprehensive revival of the Native American and indigenous community by raising awareness through health education and outreach events which honor culturally appropriate traditional healing practices. NIPIs vision is to provide support and build a safe environment for the Native American and indigenous communities. NIPIs goal is to appreciate and respect indigenous history, culture, spiritual, and healing practices. The NIPI strives to reduce stigma, provide assistance in accessing health care, and establish ongoing training opportunities for behavioral health staff and community partners.

The NIPI has further developed and articulated the following objectives:

- Increase Awareness: Improve visibility of the challenges faced by Native Americans and indigenous people and provide support for indigenous communities.
- Outreach and Education: Outreach to and educate San Mateo County employees and community partners on how better to serve indigenous communities.
- Welcome and Support: Welcome community members, clients, consumers, and family. Assist individuals in accessing and navigating the San Mateo County health care system.
- Strengthen Our Community: Provide opportunities for Native Americans and indigenous peoples to strengthen their skills and create collaboration for guidance, education, and celebration of indigenous communities.

Highlights & Accomplishments

The NIPI has not only provided mental health resources to San Mateo County residents but has also contributed to the professional development of San Mateo BHRS providers through trainings and workshops Initiative members have organized. The collaboration with CBO-Nuestra Casa, Pride Center and Phoenix Garden-BHRS has provided NIPI with the exposure to work in the community.

NIPI in collaboration with San Jose, San Francisco Indian Health Center have made efforts to engage and conduct outreach opportunities to the community. NIPI continues to promote land acknowledgement which is supported by BHRS. Continuing to provide trainings on Historical Trauma, Intergenerational Connectedness, Integrated Approach to Healing, Horticulture and Medicinal Drumming for healing. NIPI has continued its partnership with San Mateo County Libraires to further education to the community.

In FY 2021-22, NIPI participated and/or hosted the following events and activities:

- Provider training - Native American Mental Health provided by Cultural Stipend Intern
- Annual Indigenous Peoples Day: Promoting awareness to communities
- Hosted Medicinal Drumming and Spirituality as a Method of Healing and Recovery (collaboration with Spirituality)
- Participated in the 2022 PRIDE Celebration
- Participated in Honoring and Bringing Awareness to Native Lives Lost; MMIW/ Residential Schools Genocide

PACIFIC ISLANDER INITIATIVE (PII)

The Pacific Islander Initiative (PII) was initially formed by community members and BHRS staff in 2006 after a needs assessment conducted in 2005 identified particular areas of need among Pacific Islanders living in San Mateo County. The PII focuses on addressing health disparities within the Pacific Islander community by working to make services accessible and culturally-appropriate and by increasing awareness of and connections to existing mental and behavioral health services.

Mission, Vision, & Objectives

The PII's mission is to raise awareness of mental health issues in the Pacific Islander community to address the stigma associated with mental illness and substance use. The PII envisions a healthy community that feels supported by service providers, is accepting of individuals experiencing mental illness or substance use challenges and is knowledgeable of the various resources and services that are available to address mental and behavioral health needs. The goals and objectives of the PII are organized according to four pillars identified by members:

- Service Accessibility
- Sustainability and Funding
- Mental Health Career Pipeline
- Community Partnership

Highlights & Accomplishments

The FY 2021-22 continued with strengthening its virtual work and outreach to the community due to COVID-19 restrictions. Partners alike gathered to discuss their hopes and goals for the Pacific Islander Initiative. Several partners who had purposefully disengaged from the group after losing trust in its leadership were able to return, speak about their experiences, and commit to re-engaging. With this tone shift, PII embarked on the fourth year of long-term planning, building a comprehensive five-year plan that includes a youth leadership and mental health career pipeline program (Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve – PIONEERS Program). Trust, engagement, and collaboration has greatly increased over the course of the past year. During the pandemic, the community expressed a need for security and safety. PII linked families to needed services and resources by supporting COVID related campaigns and events. Additionally, PII has deepened their relationship and contact with the College of San Mateo MANA program, the co-chair Brittany Afu has been asked to join their advisory board. Partnership with the College of San Mateo has been helpful in referring students to the ethnic program and linking those students and their families to services and care.

The Pacific Islander Initiative engaged with community members directly through events and community trainings throughout the year. PII has continued to focus on reducing stigma and increasing awareness about suicide in Pacific Islander communities.

In FY 2021-22 PII participated and/or hosted the following activities and events:

- Hosted Series of Heal and Paint- Journey to Empowerment
- Leadership Workshop
- Provided COVID-19 support for PII community

PRIDE INITIATIVE

The PRIDE Initiative was founded in April 2007 and was one of the first LGBTQ focused efforts in San Mateo County. The Initiative is comprised of individuals concerned about the well-being of lesbian, gay, bisexual, transgender, queer, questioning, and intersex individuals (LGBTQQI).

Mission, Vision, & Objectives

The PRIDE Initiative has defined its mission as being committed to fostering a welcoming environment for the lesbian, gay, bisexual, transgender, queer, questioning, and intersex (LGBTQQI or LGBTQ+) communities living and working in San Mateo County through an interdisciplinary and inclusive approach. The Initiative collaborates with individuals, organizations, and providers working to ensure services are sensitive and respectful of LGBTQ+ issues. PRIDE envisions an inclusive future

in San Mateo County grounded in equality and parity for LGBTQ+ communities across the County. PRIDE objectives have been defined as:

- Engage LGBTQ+ communities.
- Increase networking opportunities among providers.
- Provide workshops, educational events, and materials that improve care of LGBTQ+.
- Assess and address gaps in care.

Highlights & Accomplishments

In FY 2021-22, the Pride Initiative experienced a change in membership as they transitioned to an in-person Pride Celebration and as a result, more community members were interested in becoming members. There was an increase in youth participants. It was remarkable to witness that youth felt safe at the event to participate in greater numbers, and it is a testament to the reputation of the event. The Pride Initiative builds upon the efforts of the last several years and based on survey data collected at the event, the reputation of the Pride Celebration is that it is a family and dog friendly, clean and sober, relaxed and comfortable event, which not only sets us apart from all other events in the region, but it has also become a draw for attendees from outside the County. Pride Initiative members have contributed to events of other organizations, such as the LGBTQ Commission and the Pride Center. The PRIDE initiative has shed light on the need to identify and promote LGBTQ+ services and providers, transgender violence, the County's outdated transgender policy, and access to the Monkeypox (MPX) vaccine. Lastly, the co-chairs of the Pride Initiative have promoted themselves in their leadership positions as community members that hold tremendous responsibilities and authority in their daily lives yet, model the need and importance to lead and volunteer.

The PRIDE initiative continues to create, support, and partner on LGBTQ+ events, with the PRIDE Center, LGBTQ Commission, and ODE's HEIs that builds community, infuses cultural humility, and addresses intersectionality. In the different stages of the pandemic, the initiative was able to put together and host the 10-year PRIDE celebration. They rebuilt those connections and created an affirming Pride Event with over 1500 people in attendance. They partnered and built new connections with Outlet- Adolescent Counseling Services, Communities Overcoming Relationship Abuse (CORA), and San Mateo County Fairgrounds to support with increasing outreach and increased recruitment to LGBTQ+ Communities of Color, working on intersectional issues around Social and Racial injustice, homophobia, transphobia, and systemic racism.

In FY 2021-22, PRIDE participated and/or hosted the following events and activities:

- San Mateo County In-Person PRIDE Week – 1,500+ attendees
- Pride Day at the Fair
- Sexual Orientation and Gender Identity (SOGI) training
- Mental Health Awareness Month
- Trans Day of Remembrance
- Black History Month Celebration

SPIRITUALITY INITIATIVE (SI)

The Spirituality Initiative (SI) began in 2009, and works to foster opportunities for clients, providers, and community members to explore the relationship that spirituality has with mental health, substance use, and treatment.

Mission, Vision, & Objectives

The SI envisions a health system that embraces and integrates spirituality when working with clients, families, and communities. They have defined three core principles that guide their work:

- Hope. The Spirituality Initiative recognizes that hope is the simplest yet most powerful tool in fostering healing.
- Inclusiveness. The Spirituality Initiative acknowledges that spirituality is a personal journey and that individuals should not be excluded from services based on their spiritual beliefs and practices.
- Cultural humility. The Spirituality Initiative encourages an attitude of respect and openness in order to create a welcoming and inclusive space for everyone.

Highlights & Accomplishments

In FY 2021-22 the Spirituality initiatives ongoing monthly meetings have become a place where a cross section of the community comes to learn more about San Mateo County BHRS, community partners/stakeholders, consumers, and family members of those with lived experience, furthermore the opportunity to interact with those who are in leadership positions have been rewarding for all. For instance, as a result of SI work and collaboration during this fiscal year for Black History Month February 26,2022 in solidarity with the African American Community Initiative, The Spirituality Initiative's current Co-chairs and the incoming Co-chair assisted in the planning and implementation of every aspect of the esteemed yearly Black History Month program. There was a request that the reading of Indigenous People's Land Acknowledgment be a part of the program which led to the addition of the African Ancestral Acknowledgment also being read during the event. It has been said that music is the soul and spirit of Black Folks. From offering musical selections by the Glide Ensemble: "Say Their Names" which chronicles contemporary African Americans murdered by police violence. A deeply significant source of sorrow and emotional pain in the African American community. Their names are said despite their horrendous demise to commemorate this tragedy by giving their lives meaning and longevity. The song "Glory" was added to the program to acknowledge a communal desire for individual and community freedom in past, present and future generations of African Americans. Equally as important, a piano recital entitled "Honey" by the talented Leon Bates was included with a description of its historic composer Robert Dett, a descendant of slaves to acknowledge ancestors was also a noteworthy part of the program. In total, AACI's Black History Month 2022 was a successful event with support.

This year SI was able to hold the National Day of Prayer event, as it had been cancelled in 2020 due to the pandemic, with mindfulness about health risk, the National Day Prayer was held on Zoom. The event featured Judaism, Christianity, Islam, Catholic, and Hindu, leaders, San Mateo Deputy County Manager Peggy Jensen, Learn, Engage, Aspire, and Perfect (LEAP) Institute Director Viral Mehta, as well as prayers/poem from consumers and providers. The planning of the event was led by the Co-Chairs of the ODE Spirituality Initiative, Isaac Frederick and Melinda Ricossa, along with consumers, members of the faith base community and community-based organizations. The event was a big success thanks to all those who helped with the planning. The 1 ½ hour virtual event drew 75 people in attendance, and many more expressed they would have attended if not for schedule conflicts.

In FY 2021-22, SI participated and/or hosted the following events and activities:

- National Day of Prayer
- Virtual Juneteenth Event- Freedom and Fatherhood
- Board & Care Training
- Black History Month 2022
- StarVista Clinical intern training

HEALTH AMBASSADOR PROGRAM - ADULT

San Mateo County's Behavioral Health and Recovery Services (BHRS) Health Ambassador Program (HAP) was created in 2014 out of a desire for community members, who are committed to helping their families and neighbors, improve their quality of life, continue learning, and increase their involvement in community services. Health Ambassadors are individuals who are committed to helping to improve the health and wellbeing of individuals in their community and complete the Health Ambassador Program. To become a Health Ambassador, community members must complete 5 of the 11 courses offered: The Parent Project, Mental Health First Aid (MHFA) and/or Youth Mental Health First Aid (YMHFA), Wellness Recovery Action Plan (WRAP), NAMI Family to Family, NAMI Basics, Applied Suicide Intervention Skills Training (ASIST), Photovoice Project, Digital Storytelling, Stigma Free San Mateo, and the Lived Experience Academy. The BHRS Health Ambassador Program was created in recognition of the important role that community members serve in effectively reaching out to others. HAP goals include:

- Increase community awareness of services available in San Mateo County and help connect individuals to appropriate care and support.
- Reduce the stigma of mental health and substance use
- Improve the community's ability to recognize the signs and symptoms of mental health and/or substance use issues and implement social change.
- Foster community support and involvement in BHRS' vision to improve services.
- Assist communities in practicing prevention and early intervention, leading to healthier and longer families.

Program Impact

Health Ambassador Program	FY 2021-22
Total clients served	36
Total cost per client	$4,235

- HAP regained a program coordinator and worked on a series of community events to support with COVID response efforts; regular HAP meetings have resumed, providing support, resources and opportunities to current Health Ambassadors.
- In October of 2021 the HAP lead began working with a contractor to streamline data collection and support data improvement efforts (screener and information gathering). Additionally, a process for tracking and supporting ambassador community events was created and is currently being implemented.
- 12/4/21 and 12/5/21: HAP supported St. Raymonds Mental and Emotional Wellness event, providing resources and responding to community questions about behavioral health services, how to access services and learn more.
- 2/7/22 HAP hosted Families with OMICRON: Stories & Resources- a livestream event that reached thousands of people around San Mateo County and other Bay Area Counties, as well as people tuned in from Mexico and El Salvador. The purpose of the event was to create a culturally appropriate/informative/healing space to: Share stories of Latinx families facing OMICRON, provide updated information on how to navigate the virus from an infection disease expert from Stanford University and share County resources.
- 4/26/22 HAP was honored with the 2022 Tony Hoffman Community Mental Health Service Award in recognition of their instrumental work providing COVID-19 support and outreach. Including the creation of PSAs to promote vaccinations, the distribution of mental health support and an array of community virtual events (held in Spanish), including “La Vacuna, Mi Bienestar, Mi Comunidad.” Health Ambassadors also started a Door-to-door canvassing in San Mateo, East Palo Alto, Redwood City, and Half Moon Bay, where they distributed masks and critical resources for the communities.
- 5/9/22 HAP supported an outreach event at Sequoia High School for May Mental Health Awareness Month.

- 5/21/22 HAP supported Sequoia Healthcare Districts Event Health Fair on the Square providing resources and answering questions about behavioral health services and supports.
- 06/05/2022 HAP volunteered at the 10-year anniversary of San Mateo County's PRIDE Celebration. The ambassadors helped collect demographic data of attendees to learn which communities were represented at the event. This support was offered in English and Spanish.

Successes

ODE successfully advocated for a permanent position and was able to hire a HAP Program Coordinator position, regular meetings resumed, providing support, resources and opportunities to current Health Ambassadors.

Challenges

Provide trainings in other languages continues to be a need. Some curriculums haven't been translated to other languages.

INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

ADULT MENTAL HEALTH FIRST AID (MHFA)

Adult Mental Health First Aid (AMHFA, the program, or the course) is an 8-hour public education course funded by the Mental Health Services Act (MHSA) and provided by the BHRS Office of Diversity and Equity (ODE). The course introduces participants to the unique risk factors and warning signs of mental health problems in adults, builds understanding of the importance of early intervention, and teaches individuals how to help an individual in crisis or experiencing a mental health challenge.

BHRS ODE works in partnership with other community organizations to facilitate AMHFA courses. Between July 2021 – June 2022 (FY 2021-22), BHRS ODE contracted with trained instructors from StarVista and Hope Oriented Wellness to facilitate courses, in addition to individual contractors. Course instructors provided 14 AMHFA courses to over 165 participants. Course participants include community members from a variety of backgrounds (*see demographics in section 6*).

In addition to the AMHFA course offerings, participants complete five surveys throughout the program to assess course outcomes. The five forms include (1) an application, (2) a pre-program survey, (3) a post-program survey, (4) a course evaluation form, and (5) a six-month follow-up survey.

These surveys collect demographic and contact information. These surveys also evaluate outcomes by assessing participants' confidence and changes in knowledge about mental health concepts.

AMHFA aims to teach community members and partners in San Mateo County about mental health risk factors, warning signs of mental health problems, and the importance of early intervention. The course also builds participants' skills in how to help an individual in crisis or experiencing a mental health challenge, shares information about mental health concepts, and disrupts common misconceptions about mental health. Surveys collected from AMHFA participants demonstrates course outcomes aligned to each of these aims.

Specifically, AMHFA incorporates culturally humble questions, examples, and resources to help participants to intervene with and refer behavioral health services to underserved populations in a more culturally responsive way. As a result, AMHFA seeks to improve timely access and linkages for underserved populations.

Additionally, AMHFA shares mental health facts and stories of hope and recovery which helps reduce stigma of mental health issues and conditions. Through the course content, instructors share local resources with participants so that they can refer their peers and fellow community members to professional behavioral health support, including public health services, which increases the number of individuals receiving public health services. AMHFA also partners with agencies that connect marginalized communities to care, including those serving older adults and incarcerated youth. Moreover, AMHFA participants come from a diverse range of experiences, including a diversity of spoken languages, races, ethnicities, and group affiliations. Through this diverse program reach, AMHFA effectively reduces disparities in access to care. Finally, AMHFA implements the recovery principles of support since participants are equipped with knowledge that empowers them to provide hope and support to those facing mental health issues in their everyday lives.

Program Impact

Adult Mental Health First Aid	FY 2021-22
Total clients served	165
Total cost per client	$436

As aforementioned, the five forms collected from participants to assess course outcomes include: (1) an application (n= 138) and (2) pre-program survey (n= 101), (3) a post-program survey (n= 110), (4) a course evaluation form (n= 117), and (5) a six-month follow-up survey (n= 8). The application gathers demographic and contact information and assesses participants' confidence to apply mental health first aid concepts in real life. The same questions are asked in the post-course evaluation form in addition to other post-course questions. After six-months of course completion, participants are

invited to answer the same set of questions as those in the application and evaluation form. In addition, participants are asked to complete a pre- and post-program survey to assess their change in knowledge about mental health concepts. Analysis of pre- and post-program surveys requires that an individual complete both surveys and answer all questions. Incomplete data, such as when a participant only completed either the pre- or post-survey rather than both or skipped individual questions, were not analyzed.

There was an increase in correct answers across all questions from the pre-program to post-program survey, indicating that the course effectively communicated educational material on mental health. Specifically, participants' awareness of the signs of a mental health episode and knowledge about common mental health disorders increased notably. For example, the following two questions had the most significant increase in correct responses from the pre to post survey:

- "It is easy for a Mental Health First Aider to distinguish between a panic attack and a heart attack." (Pre: 42% said 'False'; Post: 82% said 'False')
- "Schizophrenia is one of the most common mental health disorders." (Pre: 39% said False; Post: 73% said 'False')

Additionally, participants were also asked about their confidence in assisting someone in crisis or experiencing a mental health challenge prior to the course through the initial application and after the course through the six-month follow-up survey. Based on the results, all indicators of confidence increased by 12 to 25% from course application to the six-month follow-up survey, with all or nearly all respondents indicating confidence in each area. The two questions with the most significant increase in sense of confidence from the pre- to post-survey were:

- "I feel confident that I can…Reach out to a person who may be dealing with a mental health problem, substance use challenge or crisis." (Pre: 75% Strongly agreed or agreed; Post: 100%)
- "I feel confident that I can…Recognize and correct misconceptions about mental health, substance use and mental illness as I encounter them." (Pre: 75% Strongly agreed or agreed; Post: 100%)

The course evaluation form also assessed whether participants have a better understanding of how mental health and substance use challenges affects different cultures after participating in the course. Through the course evaluation form, 89% of participants (N=93) agreed or strongly agreed with the statement: *"As a result of this training, I have a better understanding of how mental health and substance use challenges affects different cultures."* In comparison, only 60% of these same participants agreed or strongly agreed with this statement in their application prior to the course. This comparison shows that there was an increase in understanding at the point of the evaluation.

Additionally, the course evaluation form assessed cultural relevance of the course by asking participant agreeability to the following statement: *"This training was relevant to me and my cultural background and experiences (race, ethnicity, gender, religion, etc.)."* Through the evaluation (N=93),

88% of participants agreed or strongly agreed with this statement, acknowledging that the AMHFA course was culturally relevant to most participants.

Findings from the pre- and post-program surveys indicate that participants gained knowledge about various mental health concepts and about intervening in a mental health crisis as a result of the AMHFA course. Additionally, a comparison of pre-course application responses to post-evaluation responses indicates that participants gained a sense of confidence in translating concepts learned in AMHFA to real-life. Thus, participants not only learned mental health first aid concepts, but also felt confident in doing so in their work and out in the community. With this knowledge and skillset, AMHFA participants are better equipped to reduce the duration of untreated mental illness, prevent mental illness from becoming severe and disabling, and reduce negative outcomes that may result from untreated mental illness.

Successes

The San Mateo AMHFA program is proud of the knowledge the course imparts on participants and the impact the course has on participants' ability to apply concepts and skills in real-life. With these skills, program participants can provide essential support to community members during these highly stressful times. In addition to the data gleaned from the program surveys, participant testimonials convey the impacts of the program:

"I am grateful to the County Board of Supervisors for funding Mental Health First Aid trainings in cities throughout our county. During the pandemic, community members experienced long wait times to connect with a mental health professional. It is important to bridge this gap by training community members how to appropriately respond when encountering a person in mental distress. Mental Health First Aid training gave me the tools that I needed to feel confident in knowing what to say and how to respond when interacting with someone struggling with their mental health, whether it be a loved one or someone I don't know at all. I have, in fact, already put my training to good use with a youth in my community who I met at a public event. I would strongly recommend this training. Using these tools could help save a life." - Sara McDowell, Mayor, City of San Carlos and Adult MHFA Program Participant

Challenges

During the previous FY 2020-21, no AMHFA classes were provided as the COVID-19 pandemic required urgent attention from staff qualified to teach AMHFA. During the reporting FY 2021-22, most contracted providers were working on building their staff capacity to teach AMHFA by hiring and training staff to facilitate the course. The contracted providers that were able to provide AMHFA classes provided in-person and virtual courses through Zoom. However, fewer classes were offered than in previous (pre-pandemic) years.

BRHS ODE and AMHFA also faced challenges with data collection, which was backlogged and incomplete due to constraints on staff capacity. For example, there are a few limitations of the data collection methods that impacted the resulting analysis:

- Only a very small number of individuals (8) completed the six-month follow-up survey; as such, results and findings cannot be generalized.
- Some AMHFA participants were mistakenly given a FY 2022-23 application rather than a FY 2021-22 application, and, as a result, completed slightly different demographic information related to their race and ethnicity (n=3). The analyses therefore may provide an underrepresentation of participants that identify as Mexican, Mexican American, Chicano, and/or Hispanic/Latinx.

Overall, the data collected through the AMHFA evaluation provides useful insight into the participant experience and impact of the AMHFA course. The challenges the program faced related to staff capacity and data collection are being addressed in FY 2022-23 through the hiring of additional program management staff at BRHS ODE and the streamlining of data collection processes for AMHFA program surveys.

Demographics

During FY 2021-22, AMHFA contractors served at least 165 participants across 13 classes. The AMHFA course served a diverse group of community members and partners in San Mateo County. The age of AMHFA participants ranged from 18 years old to over 60 years old, with nearly two-thirds of participants (60%) between 26 and 59 years old.

In addition to the demographics presented the table below, a small subset of participants (8%) reported having a disability, including a chronic health condition, difficulty hearing or a mental and/or physical disability. Lastly, participants reported representing a variety of groups, with the most common identifiers being community members (16%), providers of health and social services (6%), family members of a consumer/client (5%), students (5%), and law enforcement (5%). Many participants selected multiple group affiliations (18%).

Age Groups	%	Primary Language	%
18-25	10%	English	68%
26-59	60%	Spanish	6%
60+	12%	Cantonese	2%
Declined to State	2%	Another language	4%
Unknown/Not Reported	16%	Unknown/Not Reported	19%
Gender	**%**	**City of Residence**	**%**
Female/Woman/Cisgender Woman	59%	South San Francisco	13%

Male/Man/Cisgender Man	18%	Daly City	9%
Another gender	3%	Pacifica	8%
Decline to state	2%	San Carlos	5%
Unknown/Not Reported	18%	Brisbane	4%
Race	**%**	San Mateo	4%
Asian or Asian American	30%	Hillsborough	3%
White or Caucasian	27%	San Francisco	3%
Black or African American	0%	Another city	25%
Bi- or multi-racial	7%	Unknown/Not Reported	26%
Another race	6%	**Group Representation**	**%**
Decline to state	5%	Community member	16%
Unknown/Not Reported	25%	Providers of health and social services	6%
Ethnicity	**%**	Student	5%
Mexican/Mexican American/Chicano	9%	Law Enforcement	5%
Chinese	7%	Family member of client	5%
Filipino	6%	Provider of behavioral health services	1%
Bi- or multi-ethnic	6%	Multiple group affiliations	18%
Another ethnicity	6%	Another Group	2%
Central American	3%	Decline to state	4%
Decline to state	4%		
Unknown/Not Reported	59%		

STIGMA AND DISCRIMINATION REDUCTION

MENTAL HEALTH AWARENESS AND #BETHEONESMC CAMPAIGN

#BeTheOneSMC is San Mateo County's anti-stigma initiative and aims to eliminate stigma against mental health and/or substance use issues in the San Mateo County community. #BeTheOneSMC can mean many things to different people. #BeTheOneSMC's main message is that you can be that ONE who can make a difference in reducing stigma and promoting wellness in the community.

Primary program activities and/or interventions provided include:

- Inclusive Language: In October 2021 and January 2022, the San Mateo County Behavioral Health and Recovery Services facilitated open forums for San Mateo County peer organizations and community. Organizations included Behavioral Health and Recovery Services Lived Experience Education Workgroup, Voices of Recovery San Mateo County, California Clubhouse and National Alliance on Mental Illness San Mateo County. The goal of these open forums was to identify recommended inclusive language around mental health and substance use conditions. The below graphic depicts the general consensus of recommended inclusive language.

- Annual May Mental Health Month (MHM) Observance: This is one of the biggest mental health observances of the year for San Mateo County. The 2022 MHM consisted of
- Planning Committee which provided guidance and oversight for the 2023 MHM countywide virtual and in-person events. Planning committee members included clients/consumers, family members, county staff and community-based organization staff. Planning committee meetings convened from February to June 2022.
- Advocacy Days which is the opportunity for community members advocate for mental health at local city and county meetings that include dedicated agenda item on May Mental Health Month. The dedicated agenda item usually was a proclamation for May Mental Health Month. In 2022, 15 out of 20 cities in San Mateo County proclaimed May as Mental Health Month and five city buildings, in addition to the county building, were lit up in lime green – and one city raised a lime green flag.
- Event Support and Mini-Grants which is an opportunity for County and community partners to apply for event support and funding for their MHM event. This was the first year since 2019 that in-person events were offered.
    - Input/ideas on event theme, programming, communication/outreach and logistics
    - Speakers with lived mental health and/or substance use experience
    - Digital stories for screening
    - Photo voices for exhibits
    - Event flyer template
    - Event promotion on website and social media (Facebook, Twitter and blog)
    - Evaluation template
- Mini-Grants $3,000 were distributed to 9 grantee recipients (6 grantees receiving $300 and 2 grantees receiving $600):

- Community Members (3)
- Cabrillo Unified School District
- California Clubhouse
- SafeSpace
- Star Vista
- Star Vista - Health Ambassador Youth
- Voices of Recovery San Mateo County

Communication Campaign which promoted May Mental Health Month through the following communication channels. New graphics and content align with the statewide #TakeAction4MH campaign.

- Website - first standalone website www.SMCMentalHealthMonth.org (not currently active). Promotional video at https://www.youtube.com/watch?v=NbgPe84xw2A&ab_channel=SMCHealth.
- Social Media (Facebook, Instagram, Twitter) - there were 6 social media posted across San Mateo County Health Facebook, Instagram, Twitter and BHRS Blog.
- Outreach Materials – created and mailed by state and distributed by planning committee

Through above communication channels, the hashtag #SMCTakeAction4MH was featured and shared by organizations and individuals, including City of Brisbane, City of San Bruno, City of Daly City, Mayor of Pacifica, Menlo Park Library, South San Francisco Public Library, Redwood City Public Library, San Mateo Adult School, Voices of Recovery, One East Palo Alto, Peninsula Family Service, Neighbors Helping Neighbors – San Mateo County, Nuestra Casa de East Palo Alto and Poet Laureate Aileen Cassinetto.

Program impact

Mental Health Awareness	FY 2021-22
Total clients served	500
Total cost per client	$164

The #BeTheOneSMC (Stigma Discrimination Reduction) initiative

- Improves timely access and linkage to treatment for underserved populations (#1) and increases the number of individuals receiving public health services (#3) by raising awareness in the community about behavioral health resources through online communication and outreach.

- Reduces stigma and discrimination (#2) by providing education and sharing stories of those with lived experience through community events and social media.
  Reduces disparities and inequities to access to care (#4) by hosting activities that target specific marginalized communities in different regions of the county. For 2020-2021, specific marginalized communities targeted including youth, older adults, new mothers, Spanish and Mandarin speaking, people of color (including African American and Asian Pacific Islander) and LGBTQ+ community.
  Implements recovery principles (5) by integrating key recovery principles (particularly individualized and person-centered, respect, and hope) in the communication messages and framing of events.

There was a total of over 43 MHM events with collectively about 3,000+ people reached (estimated based on attendees and views of recording). 160 survey responses collected from 20 out of 43 events. Results are shown below. Of the collected responses:

- 94% (149/158) are MORE willing to take action to prevent discrimination against people with mental health conditions.
- 18% (28/158) are MORE likely to believe that people with mental health conditions are never going to contribute much to society.
- 89% (141/158) are MORE likely to believe that people with mental health conditions can eventually recover.
- 94% (149/159) are MORE willing to seek support from a mental health professional if I thought I needed it.
- 90% (143/159) are MORE willing to talk to a friend or a family member if I thought I was experiencing emotional distress.
- 89% (141/159) learned how to better care for my mental health and seek help if need it.
- 90% (142/158) agree that this program was relevant to me and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc.).

Successes

The stigma discrimination reduction program manager is especially proud of the following two program successes:

Website: The standalone MHM website was positively received as shown by the quantitative metrics referenced above and anecdotally from community partners. The website was a hub with all communication materials, including social media calendar, resources, graphics and more. A local

community partner said, “Just want to say thank you for creating such an amazingly well organized press kit, website, social media calendar, compiling resources, and graphics for Mental Health Awareness month. It's really easy to use and I can tell that y'all worked hard to make it happen. Staff are so proud to share these!” (Marilyn-Rose Calosing Fernando, She/ Her/ Hers, Marketing and Community Engagement Lead, San Mateo County Pride Center).

Partnership with Mayors: The San Mateo County Mayors Mental Health Initiative (lead by individual cities) partnered with the BHRS Office of Diversity and Equity during 2022 May Mental Health Month with 4 cities launching 6 Mental Health First Aid classes, 15 cities Mental Health Month in their city council meetings, 5 cities lighting up their buildings in lime green/green and 1 city raising a green flag for Mental Health Month. This launch was just the start to an ongoing commitment to offer more mental health programs and resources across cities throughout San Mateo County.

15 of 20 cities in San Mateo County proclaimed May Mental Health Month five city buildings were lit up their buildings in green to symbolize mental health awareness month.

Brisbane, May 2022

South San Francisco, May 2022

Challenges

As similar to previous years, the main challenge and area of growth is to broaden the reach, especially to marginalized communities with greater behavioral health need . Solutions to mitigate the challenge of broader outreach include:

- Create a communication map with special emphasis on marginalized communities with greater behavioral health need (based on available county or state data)
- Media engagement (e.g., print, radio, television) to reach a very wide audience
- Targeted outreach to marginalized communities (e.g., newsletters)

Demographics

Age	%	Gender Identity	%
Age 0-25	36%	Male/Man/ Cisgender	32%
26-59	44%	Female/ Woman/ Cisgender Woman	57%
60+	18%	Transgender Male	0%
decline to state	3%	Questioning	0%
Race/Ethnicity	**%**	Genderqueer/ Nonconforming	34%
Asian	15%	Another gender identity	2%
Black/ African- American	3%	Decline to state	4%
White/ Caucasian	50%	Transgender Woman	0%
Latino/a/x or Hispanic	37%	**Disability/ Learning difficulty**	**%**
Native Hawaiian or Pacific Islander	6%	Physical/ mobility disability	N/A
Declined to State	3%	Chronic health condition	N/A
Another race/ ethnicity or Mixed Race	9%	Cognitive Disability	N/A
Sexual Orientation	**%**	I do not have a disability	N/A
Gay, lesbian, homosexual	4%	Another disability	N/A
Straight or heterosexual	82%	Decline to state	N/A
Bisexual	2%		
Queer	0%		
Pansexual	2%		
Asexual	0%		
Questioning or unsure	0%		
Indigenous Sexual orientation	0%		

SUICIDE PREVENTION

SUICIDE PREVENTION COMMITTEE

The Suicide Prevention program aims to coordinate efforts to prevent suicide in the San Mateo County community. The primary program activities and/or interventions provided include:

Suicide Prevention Committee (SPC): The purpose of the SPC is to provide oversight and direction to suicide prevention efforts in San Mateo County. The SPC meets every month. The target population is a diversity of community partners, suicide survivors and the San Mateo County community at large.

Program Impact

Suicide Prevention Committee	FY 2021-22
Total clients served	800
Total cost per client	$134

SPC prioritized the following workgroups for the following timeframes:

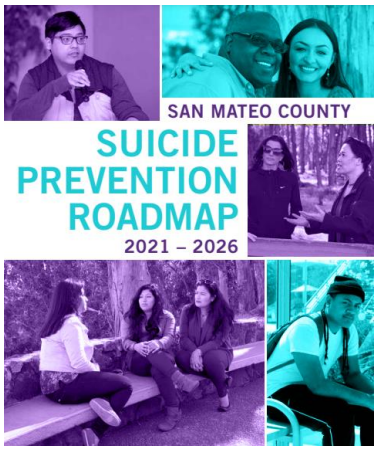
- July – December 2021: Data and Communication Workgroups
- January – June 2022: Networked Partnerships and Resource Dissemination Workgroups

Suicide Prevention Committee Co-Chairs also joined the statewide Striving for Zero Learning Collaborative. September Suicide Prevention Month (SPM): The purpose of SPM is to encourage all in the community to learn how everyone has a role in preventing suicide. The 2021 SPM theme was "Supportive Transitions: Reconnect, Reenter, Rebuild" and activities included:

- Advocacy Days
    - County Board of Supervisor proclamation accompanied by one hour recorded presentation with more in-depth updates on suicide data and suicide prevention in San Mateo County
    - 7 public comments made at the Advocacy Days at the San Mateo County Mental Health Substance Abuse Recovery Commission (September 1) and Board of Supervisor (September 14) meetings
- Events hosted by community partners
    - 6 mini-grantees that offered events designed to build community resilience and reduce stigma around suicide by covering the following areas: Celebrating and Grieving, Community Engagement, Personal Identity and Learning (from Community Activators)
    - 15 events hosted by community partners. The events targeted for various interests, age groups and languages (English and Spanish)
    - 25 survey responses across 5 events. Summary and open ended responses are attached (survey results are anonymous).

- 350+ estimated to have attended or viewed recordings for the 15 SPM events
- Communication Campaign
- Website served as a central hub of information for all SPM activities and resources
- Calendar of events and virtual background disseminated to support outreach
- 12 social media posts – including 7 in Spanish and video of suicide survivor's story
- 38,400+ views across Facebook, Instagram, Twitter and blog social media posts

Suicide Prevention Roadmap: The Suicide Prevention Roadmap development was started in October 2019 and finalized the plan which was published September 30, 2021.



Be Sensitive Be Brave Trainings:

- English Participant Trainings
  - 18 trainings – 8 Be Sensitive Be Brave for Suicide Prevention and 10 Be Sensitive Be Brave for Mental Health
  - 326 participants across 18 trainings
  - Included first Be Sensitive Be Brave trainings introduced to San Mateo County during September 2021 Suicide Prevention Month
- Chinese Linguistic and Cultural Adaptation
  - 4 pilot trainings in Mandarin – 2 Be Sensitive Be Brave for Suicide Prevention and 2 Be Sensitive Be Brave for Mental Health Trainings
  - About 137 participants across all 4 pilot trainings

The Be Sensitive Be Brave training outcome data below is for 16 out the 18 trainings. 2 trainings that are not included were under a separate contract waiver and reporting was separated.

- BSBB for SP (English)
  - Sample Size: In FY 2021-22, CCPA delivered 6 Be Sensitive, Be Brave: Suicide Prevention (BSBB: SP) trainings to a total of 97 participants. Due to incomplete survey results (e.g., participants not completing the pre- or post-training questionnaires), data were able to be analyzed from 21 to 73 participants.
  - Overall Ratings of Effectiveness: Participants rated the effectiveness of the BSBB for SP training between Very Good to Excellent (M=4.48, SD=.75 on a Likert scale of 1=Poor to 4=Very Good and 5=Excellent). Participants also reported favorable experiences with CCPA's trainers; participants rated the effectiveness of the trainers as Excellent (M=4.81, SD=.40 on the same 5 point Likert scale).
  - Qualitative Comments: Comments about strengths of the BSBB for SP training included: "[I] liked how informational it was and always kept in mind to approach

others with empathy and sensitivity" and "[The] topic reviewed clearly and was a great benefit to enhancing my knowledge on suicide prevention." When asked what participants will do differently as a result of the training, examples comments included having more conversations asking about signs and thoughts of suicide (e.g., "When I see the signs of suicide making sure I ask directly if the person has thought of attempting suicide"), referring more often for help or support (e.g., "I consider myself a help connector" and "[I will] add the numbers on my phone so it can be readily available when needed"), practicing self-care (e.g., "I plan to continue succeeding in my recovery and life enhancements."), and integrating culture and diversity into community mental health support efforts (e.g., "Definitely will be more mindful about how culture impacts the clients response" and "[I will] reevaluate how the language I use when speaking with folks about the topic of suicide, especially folks with various identities.").

  - Improvements in Individual Training Competencies: The effectiveness of BSBB for SP was also measured by conducting paired t-tests to examine pre-post training increases on an 8-item self-report measure of suicide prevention-related competencies. Results showed that BSBB for SP participants reported a significant increase in the overall mean score of suicide prevention-related competencies from pre- to post-training, the average pre-training answer was "neither agree nor disagree" (M=3.11, SD=.88) and the average post-training answer was "agree" (M=4.16, SD=.50). T-tests on individual item scores also showed that BSBB for SP participants reported large improvements in: knowledge of suicide warning signs, ability to identify someone at risk for making a suicide attempt, feeling prepared to discuss with someone their concerns about their signs of suicidal distress, suicide resource awareness, confidence in their ability to make a referral for someone in suicidal crisis, and acquisition of skills to support/intervene with someone thinking about suicide.
  - Culture and Diversity Competencies: Consistent with the BSBB: SP's specific attention to culture and diversity, participants reported large increases in their comprehension of ways in which culture affects how suicide is expressed and experienced, and in their preparedness to help people from diverse cultural backgrounds in suicidal distress.

- BSBB for MH (English)
  - Sample Size: In FY 2021-22 CCPA delivered 10"Be Sensitive, Be Brave for Mental Health" (BSBB for MH) trainings, to a total of 165 individuals. Due to incomplete survey results (e.g., participants not completing the pre-or post-training questionnaires or skipped items), data were able to be analyzed from 154 to 165 participants.
  - Overall Ratings of Effectiveness: Participants rated the effectiveness of the BSBB for MH training between Very Good to Excellent (M=4.49, SD=.67 on a Likert scale of

1=Poor to 4=Very Good and 5=Excellent). Participants also reported favorable experiences with CCPA's trainers; participants rated the effectiveness of the trainers as Excellent (M=4.68, SD=.59 on the same 5 point Likert scale).

- Qualitative Comments: Comments about strengths of the BSBB for MH training included: "This was a very informative training. Mental health is a serious issue and I think this training was very resourceful for me" and "Liked the different examples of cultural sensitivity when supporting someone with mental distress." When asked what participants will do differently as a result of the training, examples comments included having more conversations about mental health (e.g., "Be more vocal when I see something change in people I know that might signify mental health struggles and refer to assistance"), referring more often for help or support (e.g., "I plan on referring others to local and national resources more frequently"), practicing more wellness and self-care (e.g., "Be mindful of my own mental health and practice self-care more often"), and integrating culture and diversity into community mental health support efforts (e.g., "Emphasizing culture and how it affects the mental health support and conversations available").
- Improvements in Individual Training Competencies: The effectiveness of BSBB for MH was also measured by conducting paired t-tests to examine pre-post training increases on a 11-item self-report measure of mental health-related competencies. Results showed that BSBB for MH participants reported a significant increase in the overall mean score of mental health-related competencies from pre- to post-training time points; the average pre-training answer was "neither agree nor disagree" (M= 3.43, SD=.69) and the average post-training answer was "agree" (M= 4.24, SD=.57). T-tests on individual item scores also showed that BSBB: MH participants reported large improvements (i.e., as demonstrated by large effect sizes) in: knowledge of mental illness warning signs, comprehension of the difference between mental health and mental illness, understanding of 2-3 mental health diagnoses, preparedness to support someone struggle with mental health, confidence in connecting someone with mental health resources/help, ability to identify coping strategies, and knowledge of local resources/services. There was no difference pre- to post-training on feelings of inadequacy associated with seeking psychological help from a therapist, but there was a small to medium decrease in perceptions of stigma and discrimination towards individuals with mental health conditions ("Most people in my community would treat someone who has been treated for a mental illness just as they would treat anyone else").
- Culture and Diversity Competencies: Consistent with the BSBB: MH's specific attention to culture and diversity, participants reported medium to large increases in their comprehension of ways in which culture affects mental health/mental illness, and in

their preparedness to help people from diverse cultural backgrounds with mental health concerns.

- BSBB for SP and MH (Mandarin)
    - The 6-step BSBB cultural and linguistic adaptation process for the Chinese / Mandarin Chinese speaking community yielded numerous changes to the BSBB for SP and BSBB for MH training content and delivery. Notably, the core competencies and content areas of the training remained the same after the adaptation process; the vast majority of changes focused on language and training delivery-related areas. A list of each adaptation is provided in attached report titled, "Culturally Responsive Mental Health and Suicide Prevention Community Trainings in San Mateo County"
- Suicide Prevention Month
    - 58% (15/26) respondents strongly agreed or agreed that they are better able to better able to recognize the signs, symptoms and risks of suicide.
    - 81% (21/26) respondents strongly agreed or agreed that they are more knowledgeable about professional and peer resources that are available to help people who are at risk of suicide.
    - 89% (23/26) respondents strongly agreed or agreed that they are more willing to reach out and help someone if they think they may be at risk of suicide.
    - 50% (13/26) respondents strongly agreed or agreed that they know more about how to intervene (they've learned specific things they can do to help someone who is at risk of suicide).
    - 85% (22/26) respondents strongly agreed or agreed that they learned how to better care for themselves and seek help if they need it.
    - 77% (20/26) respondents strongly agreed or agreed that the program was relevant to them and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc.).

Successes

For the suicide prevention program in 2021-2022, the interventions staff are most proud of are listed below. There is also a 2022 Suicide Prevention Committee Year in Review attached which includes accomplishments from half of FY 2021-22 (January – June 2022) and FY 2022-23 (July – Dec 2022).

- 2021-2026 Suicide Prevention Roadmap
    - As of September 2021, one of only 13 California counties to have a suicide prevention strategic plan.
    - First county to add equity focus to suicide prevention strategic plan goals.

- Be Sensitive Be Brave Training Adaptation
    - San Mateo County is the first County to fund linguistic/cultural adaptation of Be Sensitive Be Brave training co-created by Dr. Joyce Chu and Santa Clara County
    - In partnership with Dr. Joyce Chu and Chinese Health Initiative, San Mateo County helped complete the Be Sensitive Be Brave adaptation for Mandarin and Cantonese speaking Chinese community (first and only linguistically and culturally adapted mental health/suicide prevention community helper training for Chinese community).
    - Participant input is listed below, including original Chinese text and English translation by Google Translate.

Question: 請分享對此訓練的意見，有**哪些地方您覺得特別好**： **Please share any comments about strengths of this training:**	
Chinese	**English**
“提供的資料很豐富。整體演講很有邏輯，系統化的介紹，很容易理解。”	**The information provided is plentiful. The overall speech is very logical, systematic introduction, and easy to understand.**
“分享亞裔資源”	
“内容很丰富哦，资料很清楚，容易理解。”	**The content is very rich, the information is very clear and easy to understand.**
“我觉得要讲的几个问题都讲的很清楚。比如，询问对方有没有自杀意图会不会造成对方自杀这个问题。”	**I think the questions I want to talk about are very clear. For example, asking whether the other party has suicidal intentions will cause the other party to commit suicide.**

Challenges

The main challenge was gathering a wider audience to participate in suicide prevention activities such as Suicide Prevention Month events or trainings. Mental Health is a more palatable subject and suicide tends to have more stigma than mental health in general.

Demographics

Age	%	Sex assigned at birth	%
Age 0-15	4%	Male	N/A

Age 16-25	10%	Female	N/A
26-59	66%	Decline to state	N/A
60+	18%		
Primary language	**%**	**Gender Identity**	**%**
English	65%	Male/Man/ Cisgender	19%
Spanish	2%	Female/ Woman/ Cisgender Woman	75%
Mandarin	15%	Transgender Male	0%
Cantonese	4%	Transgender Woman	0%
Russian	1%	Questioning/ unsure	1%
Another Language	2%	Genderqueer/ Nonconforming	2%
Decline to state	1%	Indigenous gender identity	0%
Race/Ethnicity	**%**	Another gender identity	0%
Asian	38%	Decline to state	3%
White/ Caucasian	29%		
Black/ African American	6%		
Another race/ethnicity	10%		
Decline to state	13%		
Another sexual orientation	0%		
Decline to state	0%		

PEI STATEWIDE PROJECTS

California Mental Health Services Authority (CalMHSA)

CalMHSA implements PEI Statewide Projects including Suicide Prevention, Stigma and Discrimination Reduction, and the Student Mental Health Initiative. CalMHSA is a Joint Powers Authority (JPA), formed July 2009 as solution to providing fiscal and administrative support in the delivery of mental health services.

SAN MATEO MENTAL HEALTH AND REFERRAL TEAM (SMART)

The SMART program is to provide San Mateo County's residents with a comprehensive assessment in the field and offer an alternative to Psychiatric Emergency Services when appropriate; or if needed to write a hold status and provide secure transportation to the hospital. SMART serve any resident in psychiatric crisis regardless of age as identified by Law Enforcement. Primary program activities include consultation to law enforcement on scene. SMART can write a 5150 hold if needed and transport the person. If the individual does not meet the 5150 criteria the SMART medic can provide support and transportation to an alternate destination, i.e., crisis residential facility, doctor's office, detox, shelter, home, etc.

Program Impact

SMART	FY 2021-22
Total calls received	577
Total cost per client	$56

The San Mateo Mental Health Assessment and Referral Team (SMART) contract with American Medical Response has been providing 5150 evaluation and transport services since 2005. The SMART goals and measures for FY 2021-22 are in below and both goals have been met successfully.

- SMART had 577 calls they responded to.
- The highest volume of calls was Monday through Thursday.

SMART's first goal is to divert 10 % of calls where a 5150 was not already placed. AMR has succeeded in surpassing this goal.

- FY 21-22 AMR diverted 29.2% in the first quarter, 28.3% in the second quarter, 25.5% in the third quarter, 39.1% in the fourth quarter.

SMART's second goal is to respond to 75% of appropriate calls for service.

- In FY 21-22 AMR responded to 55.9% in the first quarter and 47.8% in the second quarter, 82.5% in the third quarter, 94.2% in the fourth quarter.

SMART evaluates people in the field and able to connect people to behavioral health services upon activated by a law enforcement officer that would otherwise not have occurred. Being able to transport people right on the spot to the appropriate services has increased connectivity and

treatment for many people, especially at the moments when they needed the services the most i.e., when they are contemplating harms to self, to others, or are at the verge of grave disability.

SMART Medics evaluate individuals for both physical and mental health issues including suicidal ideation and direct people to the appropriate resources. SMART also responds to many people under 18 who are in emotional crisis – often peer related problems, family issues, and/or substance use issues as means to cope with life stresses. By addressing the youth's concerns and getting supportive and protective factors in place so that the youth can receive needed support timelier, which then support the youth to be more likely to remain in school and helps the family unit to stay intact. This is also achieved when SMART responds to parents in behavioral health crises and get them directly involved in services.

SMART responds to many homeless severely mentally ill adults. By getting them evaluated timely and facilitating access to the right level of medications and services, their mental illnesses may be stabilized sooner and resources to address their homelessness can be made available to them. SMART will also connect individuals who are not already on a 5150-hold but meeting criteria for stabilization services to such programs, an example of which is Serenity House.

EARLY PSYCHOSIS PROGRAM- (RE)MIND

The (re)MIND® program is a coordinated specialty care model for prevention and early intervention of severe mental illness that specializes in early intervention for schizophrenia spectrum disorders. (re)MIND® delivers comprehensive assessment and treatment grounded in wellness, recovery and resilience to youth and young adults experiencing early symptoms of psychosis with evidence-based and culturally responsive interventions. The (re)MIND/BEAM aftercare program – (re)MIND® Alumni – was developed to provide program graduates and caregivers with a specialized safety net to sustain gains achieved through engagement in psychosis early intervention. The (re)MIND® and BEAM programs serve the following regardless of insurance status:

- Residents of San Mateo County -and-
- Between the ages of 14 and 35 -and-
- Identified as being at risk for the development of psychosis (having subthreshold symptoms that do not meet justification for a diagnosis OR having a first degree relative with a history of psychosis AND a recent significant decline in age-appropriate functioning) -or-
- Have developed symptoms of psychosis for the first time in the past two years

In addition, (re)MIND® Alumni serves individuals who have graduated from (re)MIND/BEAM and elect to receive active support to maintain engagement in educational or vocational activities, and further develop skills to self-navigate community resources. (re)MIND® provides a wide array of services designed to wrap around the individual and their family members involved in treatment. Services start with an outreach and education campaign that helps members of the community and providers

detect early warning signs and reduce the stigma associated with psychosis. Once a youth or young adult has been identified and referred to the program, they receive a comprehensive, research-validated diagnostic assessment to determine their diagnosis with high degree of accuracy and their eligibility for early intervention services. Following assessment, individuals participate in assessment feedback session(s) where they receive psychoeducation on diagnosis and treatment options.

- Besides early diagnosis, program services include up to two years of:
- Cognitive Behavioral Therapy for Psychosis (CBTp)
- Algorithm-guided medication management
- Individual peer and family support services
- Psychoeducational Multifamily Groups (MFG)
- Supported Employment and Education using the Individual Placement and Support (IPS) model
- Strength-based care management
- Community-building activities such as program orientation for new participants and their families

Upon completion of services, either by reaching two years in the program or by achieving treatment and recovery goals early, program participants take part in a graduation ceremony to acknowledge their accomplishments and positive transitions. After graduating, participants are offered an opportunity to extend care with their (re)MIND®/BEAM treatment team at a lower intensity of services for up to a total maximum of 4 years through the (re)MIND® Alumni program, to maintain treatment progress, successfully transition to higher levels of education and employment advancement, and to empower social supports to sustain the participant's recovery.

Program Impact

(re)MIND *	FY 2021-22
Clients served (unduplicated)	77
Cost per client	$3,425
Individuals reached (duplicated)	62
Total Served	139

** Unduplicated clients served are individuals that receive early psychosis treatment and aftercare, individuals reached includes families and caregivers.*

Outcome Indicators

Domain	Indicators/Questions	#	%
General mental health	Improvement engagement in meaningful activities (employment, academic placement/progression, volunteerism) for participants and alumni	75/77	97%
	CANS – psychosis (improvement in score by at least one point or maintenance in score of 1 from initial to follow-up for participants and alumni) – in program >1yr for assessment of score change	27/33	82%
Utilization of emergency/ crisis services	Reduction in hospitalizations (both number of days and number of episodes) for participants and alumni	74/77	96%
Self-empowerment	"Due to this program, I can take control of aspects of my life" Disagree Strongly; Disagree; Neither Agree/Disagree; Agree; Agree Strongly for participants and alumni	N/A*	N/A
Stigma Reduction	"Due to this program, I am able to understand myself better." Disagree Strongly; Disagree; Neither Agree/Disagree; Agree; Agree Strongly for participants and alumni	N/A	N/A
	"I think that people with mental health challenges can lead healthy lives." Disagree Strongly; Disagree; Neither Agree/Disagree; Agree; Agree Strongly for participants and alumni	N/A	N/A

*****The development and implementation of the PEI Reporting Frameworks occurred late in the reporting period; some indicators are being collected starting FY 23/24.

Demographics

Age (N=77)	%	Gender Identity	%
Ages 0-15	9%	Female/Woman/Cisgender Woman	45%
Ages 16-25	69%	Male/Man/Cisgender Man	49%
Ages 26-39	22%	Genderqueer/Gender nonconforming	3%
Primary language	**%**	Trans Male	3%
English	99%	**Sexual Orientation**	**%**
Spanish	1%	Gay or Lesbian	3%

Race	%	Straight or Heterosexual	61%
Asian/Asian American	10%	Questioning or unsure	6%
Black/African American	6%	Another	14%
Hispanic/Latinx/a/o	3%	Decline to State	10%
Native American/ Indigenous	1%		
Native Hawaiian/Pacific Islander	3%	**City/Region**	**%**
White/Caucasian	18%	Atherton	1%
Other	34%	Burlingame	4%
More than one race	17%	Daly City	9%
Decline to State	9%	East Palo Alto	4%
Ethnicity	**%**	Hillsborough	3%
Asian Indian/South Asian	1%	Menlo Park	5%
Black/African American	5%	Millbrae	3%
Chinese	3%	Pacifica	9%
Central American	3%	Redwood City	13%
Eastern European	3%	San Bruno	8%
European	3%	San Carlos	8%
Filipinx/a/o	9%	San Mateo	21%
Mexican/Chicanx/a/o	36%	South San Francisco	5%
Korean	1%	Out-of-County	8%
Vietnamese	1%	**Disability/Learning difficulty**	**%**
Other Pacific Islander	1%	Chronic health condition	1%
South American	3%	Learning disability	1%
White	14%	Unknown	23%
More than one ethnicity	5%	No	74%
Another	9%		
Decline to State	3%		

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals	7	2	9
Substance Use Disorders (SUD) Referrals	0	0	0
Other Mental Health (MH) Referrals	0	14	14
TOTAL	7	16	23

Referrals to Other Services

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	0	Legal	0
Financial/ Employment	0	Medical care	1
Food	0	Transportation	0
Form assistance	0	Health Insurance	0
Housing/ Shelter	0	Cultural, non-traditional care	0
Other	2	**TOTAL**	**3**

Program Narrative

Improves timely access and linkages for underserved populations
(re)MIND® and (re)MIND® Alumni are stepped model of care programs designed to detect signs and risk states for severe mental illness at the earliest possible stages. Program eligibility includes individuals at risk for developing severe mental illness (prevention) as well as those with a recent onset of symptoms (early intervention). This allows program staff to intervene as early as possible limiting the duration of untreated mental illness and preventing symptoms from worsening by working with the individual and their family toward a path of recovery and ultimately illness remission. State timely access standards are upheld with all clients to expedite time to intake and services.

Reduce Stigma and discrimination
An important function of the program is to equip mental health providers and the community at large to identify early warning signs of psychosis. This function is provided by program staff through targeted community outreach and educational presentations. As a result of these activities, two major goals are achieved: 1) The importance of early intervention in preventing severe mental illness from limiting an individual's potential to achieve their hopes and dreams; and 2) The community broaden their understanding of psychotic experiences existing in a continuum of common human experiences rather than limited to a pathological condition. Due to the COVID-19 shelter-in-place order, the outreach programming was adapted to a digital format through didactic trainings, community presentations and open house meet-and-greets over telehealth platforms. The number of individual outreaches decreased, but the participation in community sponsored committees like Diversity and Equity Council, SOGI Collaborative, and School-Based Initiatives increased to allow for further spreading of the message reducing stigma and discrimination digitally.

Increases number of individuals receiving public health services

(re)MIND® and (re)MIND® Alumni work with public partners such as BHRS YTAC network to support youth who are transitioning out of high school-based services and would otherwise lose contact with the public mental health system. Through these partnerships, youth maintain a safety net within the mental health system until they can access public benefits and get the necessary services directly. This results in a seamless care continuum that benefits the youth and family in need of services and helps to ensure that youth in transition to adulthood do not fall through the cracks.

Reduce disparities in access to care
Prevention and early intervention services for psychosis are not yet widely available and there are barriers that are commonly experienced by those in need of these services. One such barrier addressed by the (re)MIND® and (re)MIND® Alumni programs is that insurance status is not a factor for accessing care. This eliminates barriers to specialized treatment at the earliest point in time possible. Another barrier commonly experienced by this population can be access to reliable and safe transportation. The program addresses this barrier with services offered in the community at conveniently accessible locations for program participants. During the COVID-19 shelter-in-place order, program expanded digital options for accessing care including through phone and telehealth services. Program applied for grant funding to help clients gain access to needed technology and services to access care. Clients had the opportunity to use staff support to set up cell phone plans, data networks, and to have access to donated tablets to better help them access care equitably.

Implements recovery principles
At (re)MIND® and (re)MIND® Alumni the power of the participant's goals, dreams, and aspirations guide and drive treatment. The participant's multidisciplinary team uses a holistic, strength-based approach to instill hope, empower the participant's voice, and identify the participant's goals to develop a plan centered around them. Program participants are recognized as having subject-matter expertise about themselves and are an active and central part of their own treatment team.

Successes

Client Story #1: an adult African American client entered the program in 2021 looking for help managing overwhelming voices that made it hard to focus, keep a job, and maintain a positive self-image amongst negative statements from the hallucinations. They experienced delusional thinking that others were out to harm them and were interfering with their thinking which also caused them to have difficulty maintaining friendships and follow social conversations. Client was able to utilize all of the program's services, starting therapy to start reality testing experiences, then medication management to help control urges and symptoms, then peer mentorship and family support to normalize experiences and reduce stigma and finally supported education and employment to get a car, job, and social network; things that had seemed impossible just a year earlier. Client continues to grow and has reported they feel successful and purposeful in a way they did not when the voices were "weighing [them] down".

Client Story #2: a minor Latinx client entered program in 2021 after their experience of hallucinations, delusional thinking and paranoia increased to the point that it impacted school functioning and their parents supported them in reaching out for help. They talked about low mood and anxiety in school since middle school but said that this was getting to another level of intensity with the isolation of shelter-in-place. Simple therapy was not enough support for client's needs, and they immersed themselves in all aspects of program, from therapy to family support, peer mentorship, medication management and occupational therapy. SEES support was especially helpful for this client in setting up a 504 plan and accommodations to help them succeed in school. The client has since graduated from high school and is now working and attending college, and parents have learned to support them through their challenges in a positive and rehabilitative way.

Challenges

One challenge the program faced during this recent year was in the delivery of face-to-face services. Due to the impact of COVID-19 Shelter-in-place, many clients experienced disconnection from social supports, external coping strategies, and established routines. The majority of the clients currently enrolled in the programs have done their intakes during this public health order and experienced most services remotely. The transition to more in-person services was received with mixed reviews by clients who had grown accustomed to digital mental health care. Program staff have noticed overall that clients over time adapted well to home and field-based services in general and moved to the office as their symptoms remediated. While clients who started with in-person services continued to do so as the expected modality for care. The program's initiation of groups was attempted virtually at first but was entirely unsuccessful until in-person services were re-established. At this time, the program offers both an occupational therapy and a family support group run each week with 3-10 participants each.

Another challenge faced by the program this past year was the experience of staffing changes. During this year, the program experienced transitions in two difficult-to-fill positions, Psychiatric Nurse Practitioner and Clinical Care Manager (Therapist). While the shortage of qualified prescribers is well known systemically, the shortage of qualified therapists is a more recent challenge that is following the pandemic. To mitigate these challenges, (re)MIND® has been aggressive in adjusting compensation to remain competitive with the current market, has allowed for hybrid work schedules for staff, and supported intern training programs on site to help students accumulate hours with the hopes of hiring them on after graduation. As a result of these strategies, the program was able to expand into occupational therapy services, hired a bilingual psychiatric nurse practitioner, and at the time of this report, is nearly fully staffed with therapists.

PRIMARY CARE INTERFACE

The Primary Care Interface (PCI) program is funded 20% CSS, 80% PEI.

Program purpose: The purpose of the Primary Care Interface (PCI) program is to integrate mental health services within primary care. The program partners with San Mateo County primary care clinics to provide easier access to mental health services. The program started in 1995 at one clinic and is now embedded in five different primary care clinics throughout the county. Since its inception, the program staff grew from one therapist and nurse to a multidisciplinary team with more than 23 staff who are marriage or family therapists, licensed clinical social workers, and case managers.

Target population served: The program serves all age groups, from children as young as 3 years to the geriatric population. The program is offered to those with mild to moderate mental health issues. Around 60% to 70% of the clients are covered by Medi-Cal, while the remaining clients are covered through the county health insurance program, Access and Care for Everyone.

Primary program activities and/or interventions provided: The primary care clinics use the PHQ-2 and PHQ-9 and the adverse childhood experience screener for adults and children visiting the clinics. Once diagnosed with mild or moderate mental health issues, clients are offered appropriate mental health services and referrals to treat these issues. Referrals are made to provide support for treating alcohol use disorder (AUD) and substance use issues as well.

Program Impact

Primary Care Interface *	FY 2021-22
Clients served (unduplicated)	2,846
Cost per client	$470

Outcome Indicators

The development and implementation of the PEI Reporting Frameworks occurred late in the reporting period, so the data is not representative of the full reporting period. This data will be collected moving forward for the current fiscal year.

Demographics

Table below summarizes the demographic information for the 2,846 clients who were admitted and actively a part of the PCI program during the FY 2021-22.

Age category (N = 2,846)	%	Race	%
0–15	25.2	Other	73.6
16–25	23.6	White/Caucasian	9.0
26–59	42.4	Black	1.7
60+	8.8	Other Asian	1.6

Primary language	%	Filipino	1.6
Spanish	50.1	Multiple	1.5
English	41.6	Chinese	0.6
Portuguese	3.1	Asian Indian	0.2
Tagalog	0.5	American Native	0.1
Other Non-English	0.5	Other Pacific Islander	0.1
Arabic	0.3	Korean	0.1
Mandarin	0.3	Hawaiian Native	0.1
Russian	0.1	Vietnamese	0.1
Farsi	0.1	Hispanic	0.1
Korean	0.1	Samoan	0.1
Cantonese	0.1	Guamanian	0.0
American Sign Language	0.0	Unknown / Not Reported	9.4
Vietnamese	0.0	**Ethnicity**	**%**
Other Chinese Language	0.0	Hispanic or Latino	71.5
Hebrew	0.0	Not Hispanic or Latino	21.5
Samoan	0.0	Unknown / Not Reported	7.0
Armenian	0.0		
Unknown / Not Reported	3.0		
Sex assigned at birth	**%**	**Sexual orientation**	**%**
Female	62.0	Straight or heterosexual	21.0
Male	37.9	Decline to state	1.7
Unknown / Not Reported	0.1	Bisexual	1.6
		Lesbian or gay	0.9
		Another	0.6
		Queer	0.1
		Asexual	0.0
		Unknown / Not Reported	74.1

Program Narrative

In FY 2021–22, the PCI program served 2,500–3,000 clients in San Mateo County. The program ensured timely access to mental health services by being on site in primary care. The clients served had immediate access to mental health services if needed during their clinic visit. The PCI team allotted 30-minute appointment slots weekly, which were used to gather paperwork and provide either a warm handoff or an urgent referral depending on the need of the clients. Clients are

referred, based on their needs, into psychiatry, therapy, case management, or all three in some cases. Often when the volume of clients at the clinics becomes high, instead of turning the clients down or making them wait, the program refers them to specific providers within their private provider network (PPN). The clients who are on the lower end of the depression scale, those who may not need a prescriber attached to them, or those who may not need case management are referred to providers in the PPN.

The PCI program also provides direct substance use counseling. Case managers assess clients using American Society of Addiction Medicine criteria and authorize them into a residential treatment program when necessary and appropriate. Most clients in need of mental health services are seen by psychiatrists in house, and referrals are made to receive a higher level of care if clients meet a specific criterion. When referrals are made, the PCI team follows the clients until they are handed off to the next team. Clients are also referred to the PPN, where they are matched with an appropriate provider.

By embedding mental health services within primary care, the program helps reduce stigma and discrimination. Since the clients are familiar with the primary care clinic, they feel the mental health services are offered to support their overall health as opposed to going to a clinic that is labeled "mental health." The PCI team also reduces stigma for clients experiencing AUD or substance use disorders by using a disease model approach. Embedding these services within primary care allows primary care physicians to work with each client to establish common goals and use a harm reduction approach instead of an abstinence approach to treat their issues.

The PCI program welcomes all clients who need services. Their motto of "no wrong door" enables them to serve close to 3,000 clients every year. They meet all the clients and after assessment decide whether their team can cater to their needs or they need a different service, in which case they are referred to the team providing that service. The PCI program also partners with other organizations in the community such as community-based organizations, school systems, and trauma centers to provide the needed services to clients. When these partners are at capacity, the PCI-participating clinics will then refer the clients to the PPN. To reduce disparities in access to care, the primary care clinics that often receive clients who are Spanish speakers are supported by bilingual staff in the clinics. Interpreter lines are available for those who need services in other languages like Tagalog and Portuguese. The program also offers both in-person and telehealth appointments, as well as appointments in the evenings.

The PCI program uses a client-centered model in which services are voluntary, and the client can choose one or more services offered by the program. So, for example, clients can select therapy, medications, or case management or select all based on what they need. The program offers clients the chance to actively participate in their treatment decisions, planning not only what their goals are but also who they want involved in their recovery—a family member, spouse, or friend. The program also has staff who have different levels of training (e.g., in Neurosequential Model of Therapeutics),

are certified in providing behavioral health services, and take their annual cultural humility trainings—these factors enable the team to offer a client-centered model.

Successes

One of the biggest successes of the program was the increase in show rate for appointments. Offering a client-centered model allowed the clients the ability to choose the modality that best works for them. Flexibility in selecting the time of the appointment (e.g., evenings) or providing telehealth as an option helps those who are unable to miss work or have difficulty traveling for appointments.

Warm handoffs to other providers within the network have provided continuity of care to clients. The PCI program integrated with the BHRS prescribers as part of the community interface provider network. Providers in this network managed those clients who do not need a higher level of care at regional centers and often do well with medical management (e.g., anti-psychotic medicine or mood stabilizer). Providing services within the network helped with continuity of care and helped prescribers keep track of the medications and other services that are being provided to the clients. This also helped reduce the stigma associated with getting mental health services because these services are integrated within primary care.

Client Story: Cindy (real name not revealed to maintain client privacy) had been referred to the PCI program 3 times over the last few years. They decided to engage in services after experiencing health concerns related to substance use. Cindy presented with a history of methamphetamine use, depression, Post-Traumatic Stress Syndrome (PTSD), epileptic seizure disorder, and family history of substance use/homelessness. Cindy's father passed away due to an overdose of "pills." Their mom attempted suicide and is currently homeless with their brother and using substances. Cindy's methamphetamine use had impacted their seizure disorder, and they had a seizure in front of their son, which prompted them to change their life. Cindy enrolled in services with Interface's co-occurring case management services, therapy, and psychiatry and discontinued their use of methamphetamine. While receiving treatment, Cindy's apartment was damaged by a fire, leaving them and their son homeless. They entered a family shelter where they continued to meet with PCI for services. While receiving services, Cindy was identified as meeting the criteria for the mainstream housing program and worked with their co-occurring case manager to complete the referral process. Cindy was deemed eligible for the "mainstream program and found a 2-bedroom apartment for their family. When services ended, Cindy had 14 months favorable, had stable housing, and was employed.

Challenges

In response to the COVID-19 pandemic, the PCI program saw an approximately 50% increase in adult referrals and close to a 100% increase in youth referrals in FY 2021–22. The program had not seen

such a high surge in referrals since its inception. It was difficult for the program to hire new staff to meet the increase in referrals. The situation was exacerbated when existing staff decided to stay at home during the pandemic or leave the Bay area due to high cost of living. This created vacancies in the PCI clinics (e.g., prescribers, case managers), which were difficult to fill during the pandemic. Existing staff were also involved in vaccination efforts, tracking paperwork and other tasks, which resulted in an increase in their overall workload resulting in fatigue, low morale, and often feeling unsupported. To alleviate some of the issues with staffing, the PCI team hired one medical assistant who took care of the paperwork, thereby allowing existing case managers and prescribers to see patients.

Client Story: Tara (real name not revealed to maintain client privacy) was identified as meeting M2M criteria and was sent to Health Plan of San Mateo (HPSM) for provider match. When Tara called to get an appointment, it went to an automated answering system, not a live person. They reported not hearing back from HPSM. One Interface provider called to inquire on the referral and was unable to get an appointment for the referral. It took 10 days for the Interface provider to get a call back, and when they did, the HPSM stated that the client's case was closed. HPSM reported that they do limited outreach and if Tara was not available to answer when they called, the case was closed.

At around the same time, the Health Plan of San Mateo (HPSM) took over the contract to offer mental health services to clients experiencing mild to moderate illness. Prior to this change, the PCI program had transparent processes in which staff could match clients to providers and do a warm handoff allowing clients to be tracked throughout the process. With a change in contract, it became difficult for the program staff to refer their clients to specific providers, thereby creating a gap in whether clients received specific services after being referred. With the new system, the PCI program made referrals to the access call center that would send clients to a health plan for provider matching. It often takes weeks for clients to get an appointment after referrals are made. These issues resulted in a decrease in access to care for those referred as the PCI program was not able to track the clients, and many didn't get matched to a provider for weeks. In some cases, clients called the PCI program asking who the providers are, but the program staff were unable to provide this information. Instead of speaking to a live person, clients often got a voicemail or an answering machine when they were referred to HPSM to access services. Moreover, the new system is only available in English, therefore making it difficult for non-English language speakers to access care after a referral was made.

Another programmatic need is to have prescribers who are bilingual. Although interpreter services are available, it is desirable to have prescribers and other staff who are bilingual at some clinics where close to half of the clients served speak only in Spanish.

RAVENSWOOD FAMILY HEALTH CENTER

Ravenswood is a community-based Federally Qualified Health Center (FQHC) that serves East Palo Alto residents. Ravenswood provides outreach and engagement services and identifies individuals presenting for healthcare services that have significant needs for behavioral health services. Ravenswood outreach and engagement services are funded at 40% under CSS and the remaining 60% is funded through Prevention and Early Intervention.

The intent of the collaboration with Ravenswood FQHC is to identify patients presenting for healthcare services that have significant needs for mental health services. Many of the diverse populations that are now un-served will more likely appear in a general healthcare setting. Therefore, Ravenswood FQHC provides a means of identification of and referral for the underserved residents of East Palo Alto with SMI and SED to primary care based mental health treatment or to specialty mental health.

Ravenswood	FY 2021-22
Total clients served	544
Total cost per client	$78

ACCESS AND LINKAGE TO TREATMENT

Community outreach collaboratives funded by MHSA include the East Palo Alto Partnership for Behavioral Health Outreach (EPAPBHO) and the North County Outreach Collaborative (NCOC). The collaboratives provide advocacy, systems change, resident engagement, expansion of local resources, education and outreach to decrease stigma related to mental illness and substance use and increase awareness of and access and linkages to culturally and linguistically competent behavioral health, entitlement programs, and social services; a referral process to ensure those in need receive appropriate services; and promote and facilitate resident input into the development of MHSA funded services. See Appendix 9 for the full FY 2021-22 Outreach Collaborative Annual Report.

NORTH COUNTY OUTREACH COLLABORATIVE (NCOC)

The North County Outreach Collaborative's program purpose is to connect people who need services and support around mental health, alcohol and drug treatment, medical and other needed social services. The North County Outreach Collaborative aims to reduce stigma and discrimination of mental illness along with alcohol and other drug issues by increasing awareness of available resources through education and creating access to care for those in the community who are underserved. The North County Outreach Collaborative continues to establish effective relationships with culturally and linguistically diverse community members to assist in increasing Behavior Health and Recovery Services capacity and performance in addressing the specific needs of various populations that are prominent in the North County of San Mateo such as, Filipino, Pacific Islander, Latin, Chinese and LGBTQ+.

The collaborative has learned that to help create linkages to services, knowing the individuals improves the connection with assisting in a warm hand off. Trust is the key factor to helping make the connection to services with diverse individuals and the NCOC recognizes that often they are planting the seeds of information in their various communities. The NCOC recognizes that being a consistent presence in the community allows them to then be able to water those informational seeds that were previously planted with reassurance that support is here to help. NCOC also works with service providers to better understand the diverse community and their cultural beliefs and practices. The Community Outreach Team (COT) often is the bridge and foundation that helps make the connection. When community members recognize a friendly face, a relationship has already begun, and they are then are more likely to step towards seeking support. During this rollercoaster of a pandemic this has been the driving force as the NCOC saw an increase of community folks that reached out for resources and connections. Many individuals shared that they remembered the NCOC/COT members from previous outreach events, meetings, or presentations they did. The NCOC acknowledges and practices the priority of providing a friendly welcoming smile, greeting hello, and building on a solid foundation of trust and transparency while helping empower the communities.

The North County Collaborative consists of five agencies that reside and serve in the North sector of San Mateo County.

1. The Daly City Youth Health Center (DCYHC) provides effective, safe, and respectful health services to underserved youth and young adults, aged 12-24, in North San Mateo County (NSMC) at no cost to them. DCYHC provides physician led primary healthcare, counseling services from licensed therapists, and sexual health education and social and emotional development from health educators. Every medical and counseling appointment that DCHYC provides to its client base, which is composed of low-income youth, is an example of a reduction of the disparity of access to care and an increase in the number of underserved youths receiving public health services in the community. In addition, DCYHC strives to schedule appointments in a way that the youth are receiving timely access to the care that they need.
2. Asian American Recovery Services (AARS) which is a program of Healthright360 provides an array of culturally competent services to the Asian and Pacific Islander and other ethnically diverse communities of the San Francisco Bay Area. AARS is dedicated to reducing the impact

and incidence of substance use. Programs serve youth, adults, and families in San Mateo County. AARS offers programs and services, each tailored to meet the needs of the clients/participants. Their culturally oriented, gender-responsive approaches are delivered by multicultural and multilingual staff who are a part of the communities they serve. AARS partners with government agencies, community-based and ethnic-specific organizations to strengthen the support networks available to clients/participants to engage in research and advocacy. They offer culturally tailored community-building activities that motivate the populations they serve to be resilient and healthy.

3. StarVista's Counseling Center holds the NCOC partnership for StarVista. It is committed to assuring that contracted services are provided, in collaboration with other StarVista programs. The Counseling Center provides affordable clinical services to children, youth, adults, couples, and families in San Mateo County. Other StarVista programs focus on specific populations such as pregnant mothers and families with young children, transitional age youth, the LBGTQ+ community, and individuals struggling with addiction. Some programs have specialized goals such as crisis intervention, building healthy families and teaching positive parenting, child abuse prevention and treatment, substance use recovery, supporting the LGBTQ+ community, and connecting vulnerable individuals to needed resources. Programs aim to transform lives by helping individuals improve relationships, adjust to life changes, manage work and homework stress, resolve family conflict and communication issues, improve mood, behavior, and self-esteem, learn new parenting skills, alleviate depression and anxiety, and work through identity issues, personal crises, and trauma. All programs have a wholistic, culturally respectful, strengths-based and trauma informed approach.
4. Daly City Partnership (DCP) provides mental health therapy to individuals, families, and groups, their mental health services provide to all ages, and they facilitate and organize collaboration with partner agencies for service to all clients. They also work with school district counselors to coordinate services.
5. Pacifica Collaborative (PAC) who's purpose is to connect people, share resources and support one another to enrich the community. The Pacifica Resource Center's mission is to support the economic security of Pacifica families and individuals by providing safety net of food, housing assistance and other critical services, including coaching, advocacy, information, and referral. PRC's vision is to assure the basic needs of every Pacifican are met so that each member of their community has the opportunity to thrive.

Program Impact

NCOC	FY 2021-22
Total clients served	7577
Total cost per client	$15

Overall

The NCOC Community Outreach Team (COT) met on a regular quarterly basis during the fiscal year. The general meeting did have some challenges with the pandemic scheduling and some partners being double booked and not being able to attend. Also, with one partner there was a great bit of staffing changes which in turn they did not have a representative at the table. Towards the end of the fiscal year this was in discussion and brainstorming was in effect with the partners to address.

The COT meetings were very supportive and successful in not only collaborating between agencies, but also figuring out how to be able to wrap clients/participants with needed care as a result. COT shared community resource information, outreach opportunities, collaborate on cases, and connect clients with necessary care. The COT team was a lifeline to the outreach that was being done in the community. The deep connection and caring relationships between the COT team members allowed for a safe space to work out issues, feelings and experiences that happened while doing the work. Maneuvering through the pandemic was extremely challenging for COT and having the opportunity to discuss this openly was expressed as a true gift. Most of what was shared in those meetings were extremely personal and include working through a situation of stalking, illness of family members, depression, medical issues, and lack of motivation. The highlights of all those situations were being able to cry it out, talk it out and end in love and laughter. Recognizing that the caregiver, the service provider, the on the ground outreach extraordinaire also needed a safe space to breath and unpack was a key learning factor for the Community Outreach Team.

Outreach to the Chinese Community

Daly City Youth Health Center continued to connect and engage with the Chinese community and provide translation services as needed. They have also made an effort to hire Cantonese and Mandarin speaking staff. Asian American Recovery Service partnered with Daly City Partnership to provide a cell phone for Chinese Community Referral Line 650.381.4078 which is staffed by two volunteers through HART/Daly City Partnership. StarVista's bilingual staff member outreached to the Chinese community. He had three Mandarin speaking individuals on his caseload and worked with the Chinese Hospital. Bilingual staff member who received referrals for therapy from the doctors at the Chinese Hospital then helped the referred clients find therapists. From around April forward there were very few therapists on the staff's list who were accepting new clients, so StarVista staff sent their referrals to the Access Call Center. Staff was getting about 2-6 referrals per month. Staff informed their director that the Chinese Hospital now is handling the referrals internally, so no one is needed to replace his role. The Pacifica Collaborative had two volunteers from the Pacifica Resource Center who were available to translate for both Mandarin and Cantonese speakers. There is set times during the week when they are available, and appointments are scheduled accordingly. Phone appointments have allowed for 6 families to be connected to services through their translation services. Focused Outreach to Chinese faith-based churches: Previous person who volunteered from PAC moved out the area, was able to stay connected and was able to continue the relationship with the pastor remotely to share information with the congregation about food services, funding for rent, behavioral health services and small business assistance. Promote Chinese Referral Line: Include post card sized cards at food distributions sits and in the curbside book pickups at the Pacifica Libraries 400 cards printed and distributed throughout the past year.

COVID Efforts

Through partnership with SMMC, DCYHC was able to receive information about COVID vaccination days designated for the community. Outreach for vaccination clinics taking place were shared to additional networks via email, social media posting, and networking. The DCYHC location also served as a COVID-19 testing site for community members and essential workers to get tested until January 2022. The vaccine clinic was then moved to an area that could accommodate the changing number of people. Daly City Partnership outreach was done through social media, flyers at the Daly City Community Service Center (DCCSC), weekly food distribution, volunteer appreciation event spring 2022, family resource day, and other community events. AARS was able to partner with other Pacific Islander leaders to host several key sites for PI and other community members to get tested. PAC's bulk of the outreach consisted of sharing information about COVID testing, vaccines, and resources. Printed materials were included in food distribution boxes, drive and o senior lunch programs and curbside library pickups. Links to services were shared during collaborative meetings, on social media and trough youth-led Podcasts.

Additional projects

During this fiscal year, Daly City Youth Health Center partnered with Daly City Partnership to better serve clients and expand their mental health services and support their basic needs around housing and food insecurities. There has been an increasing demand for mental health support and in order to meet this, DCYHC expanded their mental health team. Any clients they were unable to see due to capacity, were referred to Daly City Partnership. All of Daly City Partnership's community partners helped in various ways such as, Food Bank distributions, community, and special events. All their agencies worked together in supporting each organizations projects and outreaches. The Pacifica Collaborative and Daly City Youth Health Center have created working relationships that included youth outreach in both Pacifica and Daly City. The groups collaborated with SMC on a youth-led campaign to encourage young people to get vaccinated. This included youth-led panel discussions in person vaccines events and Podcasts series on youth on COVID.

During this fiscal year, staff continued to navigate the pandemic. There were some obstacles the partners overcame to stay connected to the community. For the Daly City Youth Health Center, Because of the new educational requirements from the state of California, the students at their continuation school did not have to pass health in order to graduate. This puts these students at a higher risk for unintended pregnancies, STIs, unhealthy relationships, and low self-esteem. PLAY developed special workshops to make sure that students received critical information and skill building around healthy relationships, boundaries, condoms, gender and sexuality, and consent and sexual assault.

The accessibility provided by telehealth has had an overwhelming positive response from the people DCYHC served. They increased their online therapy services to create better access for youth and other community members. The pandemic compounded mental health symptoms due to increased isolation and DCYCH saw a need to increase their services as a result. They went directly into the community to meet clients if telehealth and in-person appointments didn't work for them. They also provided transportation support for those who did not have a confidential space and preferred to come to the health center.

StarVista provided hybrid services throughout the year, working with clients to provide services in the format clients preferred. Sometimes staff arranged to meet with clients in outdoor settings (e.g., parks) to increase safety.

Daly City Partnership's one main obstacle was funding, as always. The need for mental health became very apparent and there are not enough resources out there to accommodate all those needing services. If agencies were able to receive more funding for those who don't always qualify based on income or insurance, age or where they live, then mental health can be made more available to manty. There are many therapy services available but almost always with a "Free Trial, etc." This should not be the case!

PAC-COVID has and continues to create challenges in community outreach. Relationship and trust are built through in person interactions and this has been lacking in the past two years.

In relations to the pandemic, DCYHC administration worked to adapt to meet the needs of employees, while being mindful of the health and safety of all. DCYHC implemented monthly wellness initiatives to address potential burnout that staff was dealing with. In addition, these initiatives acted as a bonding activity for staff and interns to build stronger connections with their support systems at DCYHC.

The NCOC Blog has been very challenging to participate in and upkeep. Because of the staff person who started the blog moved on, the COT team expressed they felt that many of them were not well versed on how to navigate or create content for the site. COT may look into training to help staff become more comfortable in navigating this.

Daly City Youth Health Center uses an evidence-based outcome measurement system, PCOMS (Partners for Change Outcome Management System) for collecting metrics. Client wellbeing as well as client-therapist relationship measures are collected at each session and aggregated to display treatment effectiveness. PCOMS is a well-researched, quality improvement strategy that boils down to this: partnering with clients to identify those who aren't responding to clinical interventions and addressing the lack of progress in a proactive way that keeps clients engaged while therapists collaboratively seek new directions. PCOMS has been shown to be consumer-friendly, highly feasible for clinicians, and importantly, repeatedly demonstrated to dramatically improve the quality and efficiency of services in peer-reviewed, published studies conducted across a range of settings, including public behavioral health. Measures collected at the beginning and end of every session allow us to gauge client progress across various life domains and the strength of the therapeutic relationship. In 21-22, 70.8% of the clients overall, have achieved reliable or clinically significant change.

Daly City Youth Health Center (DCYHC) mental health therapists use the Patient Health Questionnaire (PHQ)-9 to identify and treat depression, the Generalized Anxiety Disorder (GAD)-7 to monitor anxiety, and the Alcohol Use Disorders Identification Consumption (AUDIT C) and the NIDA Modified Assist for to monitor substance abuse. During treatment, mental health challenges are both reduced and prevented from becoming more severe as clients receive therapy and then continue to answer the survey questions which relate to their care. Their development is tracked through both the survey data and continued clinical assessments. Through the hard work invested by both the client and therapist, there is a very good chance that improvement will take place and that any

existing challenges will not become more severe. Each DCYHC mental health client receives a therapy plan that is individually tailored to their specific needs and continues to be adjusted through the therapeutic process. These clinic plans are designed and proven to treat and often reduce depression, anxiety, and substance abuse—all of which can reduce the likelihood of suicide, prolonged suffering, incarceration, homelessness, academic failure, removal of children from their homes, and unemployment.

StarVista programs provide direct clinical services and in doing so, reduce the duration of untreated mental illness, and prevent mental illness from becoming severe and disabling. In the FY 2021-22, StarVista provided mental health treatment to individuals in San Mateo County. In addition to the clinical services provided, StarVista also provided Crisis Intervention to people through its Crisis Intervention and Suicide Prevention program, the Community Wellness and Crisis Response Team, the Health Ambassador Program for Youth, counselors placed in schools throughout the community, and crisis intervention offered to clients who presented in crisis during ongoing treatment. Multiple StarVista programs work with individuals who have been court ordered to treatment through diversion programs or have been released from prison or jail and have mandated treatment as part of their parole or probation. Treatment focuses on developing skills to avoid incarceration. Clients in many StarVista programs experience housing insecurity and assisting them in finding resources for secure housing becomes a primary focus of care. The StarVista school-based programs have a primary focus of assisting students in resolving barriers to successful school attendance and performance. School based programs worked with students this fiscal year. Multiple StarVista programs (e.g., Child and Parent Services, Differential Response, Healthy Homes, Early Childhood Community Team) focus on care for families that are at risk of having children removed from the home. Case Management and therapeutic services are offered to assist parents in overcoming the challenges (e.g., the stress of food and housing insecurity, domestic violence, mental health issues, poverty, and discrimination) that can contribute to incidents of abuse and neglect. Multiple programs (Daybreak, Women's Enrichment Center, Insights) provide support in writing resumes and developing interview and job skills for transitional aged individuals, youth who have been in foster care, adults seeking work after periods of incarceration or unemployment due to homelessness or addiction, etc.

Daly City Partnership has been impacted by the COVID pandemic greatly. DCP continues to see an ever-increasing demand for Brain(mental) Health services. DCP clients range from 4-78 years old. DCP continues to provide wrap-around services, as well as connecting and referring to their collaborating agencies. A large increase in clients needing food and rental assistance has been higher than in past years. This coincides with the higher rates of suicidal ideation, depression, and anxiety. Joblessness and wages are also a large factor in these areas, due to lack of funding, especially when contracting COVID. 2021-22 has been a very interesting year in the field of mental health. Our Second Home (OSH) continued to offer teletherapy. OSH has adapted and has managed to continually collaborate with partner agencies such as school districts and the Daly City Youth Health Center. The mental health program continued to offer no- cost therapy to their clients. They are in the process of working with insurance companies to process medical payments for future billing. DCP was able to engage 60 youth this summer through their summer enrichment program where they introduced multiple mental health strategies. Looking at the total sessions offered this fiscal year, you can seed that despite all obstacles, OSH is committed to serving the community. All departments for the Daly City Partnership were still in full operating mode and dealing with COVID-19 and Shelter in Place (SIP) and

Stay at Home orders. Because of this, all therapy appointments were via tele therapy or virtual via Zoom. More clients have expressed anxiety and depression due to COVID-19 job losses, and now having to become their child's or children at home teacher. Many students have been unable to access online tele mental health services as they are required to use their devices for At Home Learning. (AHL) Other students have no computers or internet access and are finding it difficult to keep up with their work. Even through the world is in a pandemic, there are many, however, that are finding their ways to be grateful.

The focus or most of the LMFT sessions has been to alleviate anxiety and help those focus on how to make the best of this situation. During this time, social injustice continued to take place and rocked America to its core. Most client's sessions have been finding ways to deal with the ups and downs of the pandemic and dealing with their own feelings. Throughout the school year, many of the clients still came from the following locations: General Pershing State Preschool (GP), Fernando Rivera Middle School (FR), FD Roosevelt K-8th (FDR), Daly City Community Service Center (DCCSC), and Our Second Home (OSH). All locations are in Daly City. Many new clients were added that included teachers, school staff, mental health professionals, medical professionals, and many other individuals. Supervision of MFT Trainees began in September with the supervisions of 3 trainees. DCP is expanding their intern program for locations withing the DCP. All supervisees are under the license of the LMFT. OSH hired one additional spring/summer intern with weekly supervision. DCP was also able to hire a LMFT with Spanish fluency through Federal CDBG funding. Clients at OSH are referred from all over the school district, but primarily received via Our Second Home, General Pershing State Preschool, Daly City Community Service Center, Fernando Middle School, Susan B Anthony School, Daniel Webster Elementary School. DCP provides holistic therapies (yoga, art, music) and programs for children with special needs, and those with ACE factors. Clients are offered individual, group and family therapy in the form of Solution Focused Therapy, Cognitive Behavior Therapy, Emotion Focused Therapy as well as Art and Play Therapy. Market and manage a wraparound information and assistance program for families in the community, including community outreach and social media. In addition to posting on Facebook, Twitter, Next Door and the city's monthly newsletter, known as the "Daly Wire", Daly City Partnership and OSH post news of classes and evens on a quarterly basis through Constant Contact, which has a list serve nearly 2,000. This past year, OSH received over 400 inquiries regarding childcare, preschool, and events. Due to COVID-19, OSH's inquiries continue to address the need for food and housing assistance, and OSH continues to be instrumental in clients' accessibility to online rental assistance application and COVID 19 resource page. Check it out on www.dcpartnership.org/covid

Family and children group and individual therapy for uninsured, under supported, and underinsured referred families. The monthly "Special Needs Support Group" and social/emotional reading workshops at the preschool have taken pl ace the last year via Zoom. Over a dozen families have participated this year and appreciated the connection and the continued efforts to keep this group going virtually. Provide Individual and Group Therapy- Clients range from 4-75 years of age and come with presenting issues such as COVID-19, depression, suicidal ideation, suicidal attempts, domestic violence, child abuse, child neglect, post-traumatic stress, marital issues, self-harm, child photographing, cutting, illnesses contributing to anxiety, sexual molestation of minors and self-esteem. Implementation of safety plans are available to clients. Safety plans are given to clients after initial assessments have been done. Appropriate resources will also be used to best meet their needs.

Some of these resources are also used to best meet their needs. Some of these resources have been to local food banks, shelters, psychiatric wards, clothing resources, transportation issues, housing issues, and medical information.

“Handing a client, a phone number is not enough, but rather ensuring them that their need will be met to the best of our ability”- DCP

DCP Client Statements:

- "I am so grateful for DCP and the help they have provided"
- "You have saved mine and my child's life. I will always be grateful for what you did for me."
- "You Are Not Alone group has helped me so much"
- "I thought my life was over"
- "We are so glad that your agency has been there for us"
- "DCP does care about me"
- "My life was forever changed when I was being investigated for murder and DCP helped me through it"

Asian American Recovery Services (AARS) San Mateo County continued to serve their clients/participants via Zoom as a safety measure with the unpredictable waves of this pandemic. Their AOD program continued to thrive where clients felt that they were somewhat comfortable meeting virtually, however some did express they did miss the in-person interactions. The AARS prevention component continued to also meet with their participants virtually in programming such as the Essence of MANA Program. The Essence of MANA (EOM), which holds the core island word “MANA” is a Pacific Islander concept that represents a connection to the spirit of a higher power (Gods, Ancestors, the Universe). This concept is used to promote a holistic view of wellness (mind, body, and soul) among the Pacific Islander Populations. The EOM programs aim to increase awareness of mental health issues, reduces stigma, and create access to care and services among the Native Hawaiian Pacific Islander population. They believe it takes a village to raise a child and to create change in their community. Their goal is to reach caregivers and youth (3-17years) and begin conversations on taboo topics that impact their community wellness including: healthy relationships, domestic violence, rape/molestation, substance abuse, and mental and physical health. Through conversations, education and resource building, all parts of the family can begin a healing process to wellness. During this fiscal year they were able to serve over 30 families and share resources regarding their youth, mental health, and cultural community events. They were also able to have a staff focus on case management and giving extra support to those individuals who were in need while being able to do a soft hand off to other services available in the county. EOM was also able to bring in Pasifika community leaders to speak with the families on topics such as gang violence, alcohol and other drugs and current trends with youth, being LGBTQ and was able to show Pacific Islander Digital stories on these topics including suicide, domestic violence, rape, and molestation. This also created a safe space for the parents to talk about these topics and how it could affect their children or children’s friends. AARS was able to also have a youth prevention program for the NHPI youth ages 12-17 which was virtual in the beginning of the fiscal year and in the earlier part of the calendar year was able to meet in person with the youth. This cultural programming was able to serve over 50 participants that covered topics such as Cultural Connections, Identifying and Regulating Your

Emotions, Violence Prevention, Understanding Anger, Restorative Justice, Social Connections and Family, Substance Abuse, Social Justice, Relationships, Mental Wellness.

Essence of MANA also continued with their cultural practice of meeting virtually every first Friday of the month at Journey to Empowerment. This was a virtual space for the community to come and share stories and discuss topics that were impacting their community. Some of the topics covered were: Open Talanoa Space, Suicide Awareness, Cancel Culture in the Pacific, Game Nights, Intentions for 2022, Talanoa for Tonga, Honoring Herstory Month, Caregiving, Recovery, LGBTQ+, and Suicide. They were able to serve over 70 individuals virtually with this community space.

Because EOM programming was virtual and there was an expressed concern by the Pacific Islander community, EOM continued with their Talanoa Tuesdays Live on their Facebook page. Here they were able to invite other NHPI voices, organizations, businesses, and community folks to elevate their voices and share what they are doing in the community. It really has been a welcoming door for EOM to connect folks to their services and other social services. The highlight for EOM was to see many of their guest speakers find the courage to begin to talk about what they do. Often in the Pacific Islander community individuals are silent, humble and prefer to stay behind the scenes. With community building EOM has seen an increase of inquiries of interactions and others inquiring how EOM can expand their services to various areas. EOM has expressed that what they do can be done by anyone in their community who is willing to meet and greet others by networking and having common visions. During this fiscal year EOM Analytics were Facebook page Likes 1466, and it increased to 1793. The Total Reach on the Essence of MANA Facebook page was 39,822. They had various speakers and topics on their Talanoa Tuesday lives: Dr. Fuifuilupe Niumeitolu – Higher Education, Doris Tulifau w/ Brown Girl Woke – Samoa Aid, Tiffany Hautau – ‘Anamatangi Polynesian Voices Heartwork, Dr. Tai Faaleava – Mental Health and P.I.s, Lilian Direbes – Being a Micronesian Creative and Community Heartwork, Brandon Fuamotu – U.T.O.P.I.A. WA, Dr. Ponipate – Higher Education/Fijian Identity, Judge Masaniai – First Samoan Judge in WA, APHA Recap – Sharing Presentation Recording and Findings, Taco Tuesday Check In with MANA Team, Vaelupe Malele – PasifikaRooted Therapy/Mental Health, Tevita and Amelia Sitani – P.I. Entrepreneurship, Check In with MANA – Community Announcements, Ursula Ann Siataga – Higher Ed and SFUSD, MANA Check IN – Current Events and Announcements, Irae Hosea – Le VASA Clothing/Pressures of Familial Obligations, S.A.L.L.T. – Opening of the Pacific Islander Resource Hut, MANA Christmas/New Year’s Message, Meri Veavea – PIVOT Programing, Taco Tuesday, APV, All MY USOS. SFTRU, Lisa Joachim - Talanoa for Tonga, COVID Chronicles w/ Gaynor Siataga, Micha Faamausili – Mental Health, Fala Talk with Meri and Lu – Current Events and Community Announcements, Ellie Lefiti – Gun Violence and Re-Entry, Womens Herstory Month with the MANA Team, Nicole Lee Ellison – HAAPI and Health of the Pacific, Heartline Dedication Calls- Appreciation from the community to the community, Dr. Eneti Tagaloa – Samoan Doctor, Lola and Matt Malele – PIEFEST and Pasifika STEAM, MANA Check In, Maternal Advisory Board – PI Birthing, Ipo Taylor – First Samoan Dual Language Program, Tone Vai, Mena Moli, Jean Melesaine – Teu Le Va, SPULU – Living your Truth, Pacific Islanders Together – SMC Fair P.I. Day, MANA Check In, MANA Check In-How you doing, Glenn Castro – Music and Representation, MANA Pasefika Takeover – Pacific Islander Doulas.

Pacifica Collaborative's focus is reducing homelessness: HIPAA protected data through the Houseless on the Coast shows the correlations between the outreach efforts and securing housing for Pacifica families. Data is collected and housed at the Pacifica Resources Center. Data is also collected to show the number of folks who have accessed rental assistance in the past year and have avoided homelessness. Making the connections between regular community outreach and health outcomes of people served is not easily tracked unless the outreach worker has direct access to the client information. Outreach was conducted through food distribution, libraries, social media and other on the ground efforts are not trackable from outreach to health outcomes. Data is collected through the Pacific Resource Center Intake questionnaire which asks where did you hear about us? Pacifica School District is now collecting data to track students who receive pro-bono behavioral health services through the DCYHC. PAD also refers families to services at the PRC that includes linkages to food, rental, and housing assistance. Addressing mental health needs of children to help address the many health disparities that can arise from untreated mental illness including prolonged suffering, homelessness and school dropout rates. PAC held 9 Pacifica Collaborative Meetings and participated in monthly relevant Health Equity Initiatives (HEI) to facilitate collaboration and co-sponsoring of outreach and engagement activities and participated in the Spirituality Initiative

Successes

Daly City Youth Health Center

Since the return to in-person learning, squad members have flourished in the after-school program. PLAY had one of their strongest recruitment years and from that built a bonded and supportive squad across all JUHSD schools. Arwen Gorospe was part of the Squad Leadership at Westmoor High School:

"Since I was a freshman, I always admired those involved in Sex Ed Squad. They carried this sense of maturity and awareness, so I promised myself that I'd join one day. Then came junior year I finally took that opportunity, and I haven't looked back since. When I say Sex Ed Squad changed who I am as a person there is no doubt in that. There are so many things we have discussed and bonded over. The energy in the room is strong, filled with hope and love. Never have I ever been so involved in such an inclusive community. There was never a moment where I felt alone or excluded for my personal perspective. We held each other accountable and to a high regard. The community and the space created in Sex Ed Squad is unbeatable, we're a family.

Sex Ed Squad is more than just community service and a learning experience. There have been lessons taught that weren't on script. I have learned so much from my peers and my advisor, Sahar, through engaging conversations. The environment we built has helped me become more optimistic and feel more confident in my capabilities. Through Sex Ed Squad I developed a passion to help others, and not because of charity, but because I genuinely love seeing others smile and feel the impact of another's care. Just the same how I felt, and others felt in our weekly meetings. My squad is a group that made me feel like I belonged and not where I had to fit in. We were all different and diverse, but we all shared

admiration and gratitude for one another. Although time is limited with Squad, the lessons, the experiences, and the memories are not."

StarVista programs address more than presenting symptoms and problems, and additionally focus on the values, strengths, and life goals of clients. Evidence supported interventions are used to teach mindfulness and affect regulation, positive communication and problem-solving skills, symptom management, etc. In addition, interventions designed to increase self-compassion, self-understanding and values driven goal setting are utilized. Client directed, whole person, and strengths-based care is highlighted. Following is a success story from one of the recovery programs that illustrates that treatment extends far beyond simply not using.

Client Story (*a pseudonym): Not all people can identify a moment that shifts everything in their life. But for Deidra* it was the day in 8th grade when the students were weighed in public, and she was ridiculed for being large. That moment crystalized a feeling she had had for some time, a feeling that she was different, less than, and did not belong. She attempted suicide three times before high school. The bullying continued for years, and she learned to fight her bullies. It served as an outlet for her rage, and it built her a reputation as someone you may not want to mess with. But it got her into trouble, and it did not bring about a sense of belonging or help with her low self-esteem. In high school she was introduced to alcohol and was amazed to find something that took away the pain. With enough alcohol she found she no longer cared what people thought about her. She had temporary relief from the constant feelings of isolation and shame. More and more, she sought the numbing. Then peers introduced her to crack cocaine, and the real plunge into addiction took hold. Deidra fell into a chaotic life of physical and psychological addiction to drugs and alcohol, and engagement in various illegal and dangerous activities to support her addiction. She repeatedly was incarcerated after being caught committing crimes. Each time Deidra tried to stop using, she became flooded with the emotions associated with numerous traumatic experiences, with her isolation, and with the belief that she was a failure. She would pick up again.

When Deidra came to StarVista's Women's Enrichment Center (WEC) she was ready for things to change. She knew she wanted to stop using, but she didn't know how she wanted to live instead. She had the support and structure of her residential placement (the Catharine Center) and began the hard work of WEC. Deidra learned how to listen to and calm her emotions. She learned how to identify and communicate her thoughts, feelings and needs without aggression. Largely through feedback from the women and staff around her, she began to see her strengths: her kindness, her generosity, her humor, her loyalty, and her resiliency. Slowly, she began to believe in herself. She had the opportunity to reflect inwardly and discover her likes and dislikes and the values that are at the core of her being. She learned to plan and problem-solve, allowing her to have a greater sense of efficacy over the direction of her life. Deidra went into job training and learned a trade. She is on a union waiting list for specialized training. She has re-connected with family and has formed friendships that do not revolve around using. If you met Deidra today, you would not know of the difficult journey she has been through. You would immediately be impressed with her strong presence, her genuine kindness, her determination, and her humor. You would like her. You would laugh with her. If you took the time, you would learn from her.

In her youth, Deidra felt isolated, unseen, and misunderstood. In her addiction she was shunned, blamed, and shamed. In her recovery she discovered herself and began to be seen for who she is. Today she feels whole.

Daly City Partnership

Providing clients with resources to help them during these difficult times has been extremely helpful. One story comes from a family where the father was incarcerated due to alcohol and drug uses. During this time, the mother came to receive individual and family therapy to help her, and their children deal with this. She was also referred to resources to help with rent, food, and clothing. When the father was released, they came for family reunification therapy. Fast forward to present, family is reunited, father is in full recovery, their marriage has been restored, their house was saved from foreclosure! Both parents state, "We could not have done any of this without the help of mental health therapy and all the other community resources that made all of this possible. We are so very grateful for all that help we have received, and we will take all that we have learned through our experience, and we want to help others!"

Pacifica Collaborative

Pacifica Resource Center and Coast House: And older adult female (69) who has a history of substance use issues, mental health issues and physical disabilities was renting a room in a house for $1200.00 per month. Her income is only $600.00. This led her to make many hasty decisions which put her into a large amount of det. The stress of trying to live beyond her means also led to increased substance use and poor physical health. She caught COVID in early 2022 and her family came to the facilitator of the Pacifica Collaborative seeking services. The family was referred to Pacifica Resource Center who was very familiar with the woman in need of services and had already established a relationship with her. This allowed for a base of trust and the family came in together to create a plan. IT was very difficult, but the family decided the only path forward would be for the woman to access homeless services, work with a case manager and seek out a permanent housing voucher. The woman moved into Coast House interim housing in Half Moon Bay.

"It was scary and sad when I first moved into Coast House. Now I am more relaxed than ever before as I do not have to hustle to make rent. I have a case manager onsite, there are meals, laundry services and access to medical care. I have found ways to be of service with other clients on site and we have a sense of community I feel cared for and hopeful for my future."

"My Sisters and I all feel confident that this was the best course for our sister. We are so happy that she is getting healthy and helping others while participating in case management. We sleep better at night with less worry about her."

Pacifica Safe Parking Permit Program: The City of Pacifica has implemented a Safe Parking Permit Program for People living in motorhome who want to seek services to find permanent housing. The program could not be placed in a parking lot so there are 13 spots across the city in public right of ways. Unfortunately, 4 of the 13 spots are being appealed to the California Coastal Commission. Currently all 9 spots are being occupied and those people are connected to the Pacifica Resource Center for case management and any other services necessary. There have been two former permit holders who have access lifetime housing vouchers. This is a huge success. "This program allowed me a safe space to park and more importantly to get a good night's rest so I could go to work the next

day. It helped me be less anxious and afraid while living in the motorhome. And now, my daughter and I have our own apartment and we donated the motorhome for someone else to use!"

Asian American Recovery Services Success

AARS was able to: Improve Communication Skills Among Family Members

- The number of adults reporting they were satisfied with their relationship with their child(ren) almost doubled from pre-survey to post-survey (36% at pre and 66% at post). This positive shift was statistically significant (p=.00).

Increase Community Knowledge on signs, symptoms, and risk factors of mental health conditions (including offering and receiving support)

- In "Recognizing positive Parenting skills" more participants reported being able to recognize the difference between positive and negative skills (73% pre and 81% post), and the change across time was statistically significant.
- In "Recognizing child abuse" more participants were able to report recognizing such abuse (59% pre and 65% post) and the change across time was statistically significant.
- In "Recognizing substance use disorder" more participants were able to report recognizing the disorder (59% pre and 77% post) and the change across time was statistically significant.
- In "Recognizing mental health conditions" more participants were able to report recognizing the conditions (65% pre and 80% post) and the change across time was "near significance."
- At the end of the cohorts, more people reported knowing where to see where to seek mental health services (64% pre and 92% post) and the change across time was statistically significant, suggesting people became more aware of what is available to them.
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Reduce stigma around mental health conditions and other taboo topics (i.e., domestic violence, rape/molestation, substance use disorders etc.)

- More participants at post-survey reported being able to discuss child abuse (59% pre and 75% post) and the change over time was statistically significant.
- More participants at post-survey reported being able to discuss family counseling (60% pre and 77% post) and the change over time was "near significant."
- More participants at post-survey reported being able to discuss alcoholism / substance use disorders (56% pre and 73% post) and the change over time was "near significant."
- More participants at post-survey reported being able to discuss mental health conditions (59% pre and 75% post) and the change over time was "near significant."

AARS was also able to be a consistent presence in supporting an individual who had been connected to the NCOC partners in various ways and was connected to LifeMoves and the Access Call Center. Sadly, his psychiatrist passed, and he did not want nor to trust the system to help him, and he

disconnected from AARS and LifeMoves. His vehicle broke down and he was arrested for trespassing as he was living in his truck, and he refused to abandon it. It had been his home, his safe place for the last several years. He was then arrested again and later released, and he was able to return to his vehicle which resided outside of the tow yard. He reconnected with AARS, and they were able to convince him over time to give ACCESS another chance. LifeMoves would also do welfare checks to support him. All involved knew that patience, perseverance, time and being consistent with connecting and supporting was the key. In his time, he was willing to call the Access Call Center and they were active in trying to find a psychiatrist that would work, LifeMoves was able to help him secure housing and even though he wanted to stay in North County where he had lived, he was willing to move to South County to get off the streets. AARS helped him with furniture, essentials and some groceries and was able to connect him with Second Harvest where he volunteers and now has food on a regular basis. AARS was also able to stay connected and he shared: "Now that I am off the streets, it's going to take me awhile to adjust to not having to look over my shoulder when I am trying to sleep. You don't understand living on the streets there are a lot of crazy people who will rob you and try to kill you. I haven't had a good night sleep since I have been on the streets. I am going to just relax and try and get back to normal, I have been living in my car for four years so it is going to take me a minute before I can start to think about the things I need to do for me." It was evident that those key practices of patience, perseverance, being consistently there with support and time are the main ingredients to the steps of wellness. As several months have passed by, he is now willing to apply for SSI and is more open to help and is reaching out on his own to places like Samaritan House.

Challenges

There were many challenges this year due to COVID-19. Many clients were added due to the pandemic. The biggest challenge would have been not enough therapists to meet the high demand of incoming clients. Another challenge was helping people navigate Zoom and the idea of online usage. Most low-income individuals had limited access due to outdated devices, low internet data, etc. This in itself is not acceptable for communities. Increased funding would help with many of these areas, as well as being able to officer individual affordable internet and up to date devices on a possible "borrow" program.

AARS staff turnover greatly impacted their work, especially during a time when the virtual world acted that you could add more meetings in your day and carry more of a workload and complete these tasks efficiently with less people power. There may be some truth to that, and the fact is that the staff will do whatever it takes to finish their work, however it comes at a cost, the staff's wellness. Because of the rollercoaster of the pandemic and the increased need of support by the community, the staff have been treading water in an under toe that is trying to pull them in. Borderline to burn out is real for everyone as services did not stop during this era of COVID 19. Staff are still in transition mode of helping the community feel comfortable with telehealth and virtual classes.

StarVista experienced considerable staff turnover, including the retirement of several individuals in key leadership positions (positions that the retirees had held for decades). Like many organizations across the country, they had had trouble filling the positions in a timely manner. For some positions (especially bilingual/bicultural positions), there were no applicants for extended periods of time. The

agency offered a variety of onboarding incentives, hired a recruiter for hard to fill positions, and regularly explored ways to expand outreach. Positions slowly are being filled, and efforts are being made to enhance staff retention. StarVista has many employees at all levels who have been with the agency for over five years, and a core who have been with the agency a decade or more, but they struggle with offering salaries that support living in the Bay Area.

PAC: The challenges with the parking program lie within the hands of the neighborhood communities. The people in the neighborhoods where permit parking has been established are very angry and aggressive. The permit holders have had to install cameras outside their motorhomes to prove neighbors are blowing their horns loudly very early in the morning, throwing trash out their windows as they drive by and harassing people as they walk from their car to their motorhomes. A public service officer was hired to work with the permit holders and the community to reduce the aggression and promote peace.

EAST PALO ALTO PARTNERSHIP FOR BEHAVIORAL HEALTH OUTREACH

The East Palo Alto Partnership for Behavioral Health Outreach (EPAPBHO) collaborative is comprised of community-based agencies from the East Palo Alto region of San Mateo County to provide culturally appropriate outreach, psycho-education, screening, referral and warm hand-off services to East Palo Alto region residents. One East Palo Alto (OEPA) served as the lead agency and work in collaboration with El Concilio of San Mateo County (ECSMC), Free at Last (FAL) and ‘Anamatangi Polynesian Voices (APV). The program goals are as follows:

- Increase access for marginalized ethnic, cultural and linguistic communities accessing and receiving behavioral health services. The collaborative will facilitate connections between people who need mental health and substance use services to responsive programming (e.g., Parent Project, Mental Health First Aid, WRAP, support services, etc.) and/or treatment. Specifically, looking at how to increase access for children with seriously emotionally disturbed (SED) and adults and older adults with serious mental illness (SMI) or at high risk for higher level of care due to mental illness.
- Strengthen collaboration and integration. Establish effective collaborative relationships with culturally and linguistically diverse agencies and community members to enhance behavioral health capacity and overall quality of services provided to diverse populations. The Collaboration will improve communication and coordination among community agencies involved and with broader relevant efforts through the Office of Diversity and Equity (ODE), Health Equity Initiatives (HEI) and others.
- Establish strong linkages between the community and BHRS). It is expected that there will be considerable collaboration that would include but not be limited to mutual learning. The Outreach Workers will receive trainings from BHRS and the Office of Diversity and Equity to support outreach activities as needed (e.g., Using Cultural Humility in Asking Sexual Orientation Gender Identity Questions, Health Equity Initiative sponsored trainings, etc.) Partnership with the regional clinic(s), Access Call Center referral team and many other points of entry to behavioral health services will be prioritized by BHRS. Likewise, the collaborative

agencies and outreach workers will work with BHRS regarding strategies to improve access to behavioral health services. They will build linkages between community members and BHRS to share vital community information through the participation input sessions, planning processes and/or decision-making meetings (e.g., boards and commissions, steering committees, advisory councils, etc.).

- Reduce stigma, including self-stigma and discrimination related to being diagnosed with a mental illness, substance use disorder or seeking behavioral health services. The Outreach Workers will make services accessible, welcoming and positive through community approaches that focus on recovery, wellness and resilience, use of culturally appropriate practices including provision of other social services and engaging family members, speaking the language, efforts that address multiple social stigmas such as race and sexual orientation, and employment of peers. Specific anti-stigma activities can include, but not be limited to, community- wide awareness campaigns, education and training, etc.

The target populations served by EPAPBHO are marginalized ethnic, linguistic and cultural communities in the region including Latino, Pacific Islanders, African American/Black, and Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ+) communities of all ages.

EPAPBHO services are based on two key models of community engagement, the community outreach worker model and community-based organization collaboration.

- Outreach Workers (also known as promotores/health navigators) connect with and facilitate access for marginalized populations through culturally and language appropriate outreach and education and provide linkage and a warm hand-off of individuals to services. Outreach Workers are usually members of the communities within which they outreach to. They speak the same language, come from the same community and share life experiences with the community members they serve. Outreach Workers use a variety of methods to make contact with the community. From group gatherings in individuals' homes to street outreach and large community meetings, as well as make direct contact with target audiences, warm hand-offs and convey crucial information to provide community support and access to services.
- Strong collaborations with local community-based agencies and health and social service providers are essential for cultivating a base of engaged community members. Organizations leverage their influence, resources, and expertise, especially in providing services that address cultural, social and linguistic needs of the community. Collaboratives benefit from having regular meetings to share resources and problem solve, having a clearly defined infrastructure and consistent strategy and offering ongoing presence and opportunities for community members to engage in services.

Program Impact

EPAPBHO	FY 2021-22
Total clients served	384
Total cost per client	$265

Improves timely access and linkages for underserved populations:
Historically, the population served by EPAPBHO are undercounted and underserved. The partnership's on-going interventions provide timely access and linkages to treatment. For example, during initial screening, outreach workers engage clients when they either come in for services or when they are engaged in the community. During the verbal assessment, outreach workers help clients with presenting needs for which they are seeking services. Outreach workers listen non-judgmentally, assessing for risk of suicide or harm to self or others, give reassurance that there are local programs and services that will address whatever their specific need or concern may be. If/when appropriate, an immediate referral to the appropriate agencies in SMCBHRS' SoC is made for assessment and follow up treatment. In most cases, partners make warm hand-off referrals by accompanying the consumer member to the agency and depending on their request, participate in the initial assessment appointment. This has become a standard practice for all EPAPBHO partners particularly among monolingual speakers who need translation services and rely on an ambassador that they know and trust.

Reduces stigma and discrimination:
EPAPBHO partners are founding members of the East Palo Alto Behavioral Health Advisory Group (EPABHAG), convened by OEPA. EPABHAG was created as an advocacy group to ensure that quality mental health services are provided to EPA residents. Over the years, it has partnered with BHRS leadership to ensure that programs provided are created by the community and for the community. Major goals of the work have been to raise awareness of mental health issues and reduce the stigma associated with those issues. To this end, EPABHAG has held 12 annual Family Awareness Night events to achieve these goals with the most recent event held May 30th. Since its inception, EPABHAG has served over 1,000 residents through these events and have addressed topics including but are not limited to mental health vs. mental illness, stigma, trauma, substance use, wellness and faith.

Increases number of individuals receiving public health services:
EPAPBHO partners facilitate connections between people who may need mental health and substance use services or other social services and relevant programming and/or treatment by:

- Performing initial screening and engaging potential clients
- Provide brief interventions to engage clients
- Refer members who may need behavioral health services to appropriate agencies in the BHRS System of Care for assessment and follow up treatment as needed.

Additionally, for most clients, continued support is needed to encourage participation in follow-up treatment. On many occasions, this means providing transportation when the services are outside of the East Palo Alto community, making a phone call as a reminder and as needed, accompanying them to sessions.

Reduces disparities in access to care:
(See comments above regarding stigma and discrimination)

Implements recovery principles:
EPAPBHO partners incorporate the five key recovery concepts into outreach efforts as follows:

- Hope – People who experience mental health difficulties get well, stay well and go on to meet their life dreams and goals.
- Personal Responsibility – It's up to individual, with the assistance of others, to take action and do what needs to be done to keep themselves well.
- Education – Encouraging learning all what one is experiencing so they can make good decisions about all aspects of their life.
- Self-Advocacy – Teaching how to effectively reach out to others so that one can get what it is that one needs, wants and deserves to support wellness and recovery.
- Support – Allowing others to provide support while working toward one's wellness and giving support to others will help one feel better and enhance the quality of one's life.

MHSA Intended Outcomes:

- Reduce the duration of untreated mental illness
    - The EPAPBHO outreach form collects the following data points.
    - Has the individual had a previous outreach contact with this organization?
    - Was the individual referred to Mental Health or System of Care services?
    - Was the individual referred to Substance Use or System of Care services?
- Prevent mental illness from becoming severe and disabling
    - The EPAPBHO outreach form collects the following data points:
- Has the individual had a previous outreach contact with this organization?
- Was the individual referred to Mental Health or System of Care services?
- Was the individual referred to Substance Use or System of Care services?
- Reduce any of the following negative outcomes that may result from untreated mental illness
    - The EPAPBHO outreach form collects the following data points:
- Does the individual have any disabilities or learning difficulties?
- Is the individual homeless or at risk for homelessness?
- Is the individual a veteran?
- Has the individual had a previous outreach contact with this organization?
- Was the individual referred to Mental Health or System of Care services?
- Was the individual referred to Substance Use or System of Care services?
- Was the individual referred to other services (Emergency/Protective Services; Financial Employment; Food; Form Assistance; Housing/Shelter; Legal; Medical Care; Transportation; Health Insurance)?

Successes

Free at Last (FAL) continues strong work with patients in recovery. Its work with patients dealing with behavioral health and/or co-occurring issues is ongoing and consistent. They have a close partnership with East Palo Alto Community Counseling Center and its staff, meeting once a month or when necessary to go through cases and ensure that treatment is effective. As a response to COVID-19, Free at Last, has had to adapt to changes in the way of doing business on a daily basis to assist the patients. Patients receive services from Doctors or Therapists and most of the time works together with community contact services via phone or via zoom.

Residential treatment had successfully completed treatment during the difficult times, at the time of completion of treatment, patients had a job and were placed in Sober Living Environments after their completed treatment and FAL staff continue to support them. Free at Last reopened on September 19, 2022, and the Drop-in Center, Residential Men and Women are also reopened to full capacity. Since reopening and back to full capacity the organization is now receiving more referrals frequently from the -team.

Anamatangi Polynesian Voices (APV) recognizes that a multi-level approach to addressing the issues experienced by youth and young adults (in-school students and out-of-school) has been the intervention needed to succeed in serving families. As yet another successful intervention provided by Mamadee is her work at the Juvenile system in the County. Mamadee has been working with young people who have been referred to her by County Probation to provide intervention for these young men and their families. With her cultural/linguistic intervention, Mamadee has been successful in serving the young men and their families and connecting them to other programs in the community. A success story reported by APV is as follows:

- Dates of Service: August 4- August 29, 2022
- Requested Services: Medi-Cal, Housing, Immigration, Mental Health
- Family Size: 12 (2 adults and 10 children)
- City of Residence: East Palo Alto (EPA
- Staff: Mama Dee and Sisilia Afungia
- Client Initial: F

The F family was not new to APV, they were past clients for the father. 10 years ago, the father of the family sought assistance with his mental health challenges. Mr. F was a client at The Barbara A. Mouton Multicultural Wellness Center in EPA. At that time, he had challenges with the US Citizenship exam. Mama Dee then took him for a mental health evaluation at RFHC then referred SMMC to the psychiatry department. The psychiatry department was able to complete an evaluation therefore granting a clearance to the Department of Homeland Security and with the assistance from Community Legal Services, they were able to help Mr. F petition for his wife.

10 years later, the family was in search of APV and Mama Dee. They finally located Mama Dee for help. Their top priorities were immigration, housing, Medi-Cal and mental health. The family is living in a studio apartment for $3,200 in EPA and cannot continue to pay the high rent. Mama Dee has referred the family to Good Samaritan House as they are now on the waiting list for temporary/transitional housing. The family was then referred to RFHC for Emergency Medi-Cal and received medical care for the whole family. One of the 10 children had shown signs of depression and anxiety which was identified by the mother. She explained to Mama Dee the signs and symptoms and Mama Dee then submitted a referral to the 3rd floor BHRS clinic.

After working with the family for almost 4 weeks, there has been many changes in the behavior of the children as well as the parents. “It’s been a God send, for Mama Dee to help us understand the different systems and now I feel much lighter in my mind now. Thank you Anamatangi and Mama Dee for helping me, I cannot repay you, but I pray God will continue to bless your work and the families you help” - Mrs. F.

El Concilio of San Mateo County (ECSMC) reports There are many successes in the engagement process of the work. The fact that people had been isolated due to the pandemic was stressful in itself, but for single parents with children at home it was even more difficult. One single mother came in to the offices overwhelmed with bills, employment loss and children needing help with school work and stuck at home day in and day out. She came in to the office to request assistance for utilities through one of the programs. The pressures were evident in her conversation and emotional state. This was the entry point for staff to initiate the conversation about needing support. Some time was taken to listen and then convince her to seek support. The client left the office in a more hopeful state and agreed that she would seek mental health support for herself and the children before things got more serious for them.

Another single mother of three children came to the office for a legal referral. She had rented a part of her home to a single father with two children, but the situation became unbearable, causing her much stress and emotional problems. She had given him an eviction notice but he refused to leave. She had become depressed and fearful. She was referred to Legal Aid and to mental health services for signs of depression.

Challenges

FAL's biggest challenges this year is with the continued COVID-19 guidelines and how it has changed everything, adapting to the pandemic which causes them to continue pivoting and evolving their way of helping the community. Free at Last continues working and helping the staff mentally supporting due to some staff getting exposed or contracting COVID. The pandemic is not quite over so staff continue to follow the guidelines of the health department to keep staff and patients safe.

APV staff have definitely experienced the impact of COVID-19 on their families throughout the pandemic. In-person gatherings and face-to-face meetings are the methods of engaging Pacific Islanders (PI) and young people in the community. Over the years, raising awareness and reducing stigma around mental health have been conducted through creative PI gatherings such as music, song, dance and drumming as well as meals. Home visits have been the way to reach parents about their children, meeting face-to-face, explaining processes of school systems, social service systems, behavioral health systems and supporting their navigation have been Mamadee and her team's success. However, COVID-19 exacerbated the barriers that families have dealt with, leading to clients and families suffering in silence from the pandemic, depression, unemployment, health issues, undocumented status, etc.

To mitigate the challenges, APV has pivoted their outreach and referral process to include wellness checks via phone and email, delivered wellness packages to homes, referrals and warm hand-offs to community resources and assistance programs. Challenges to engaging youth and families include certain processes such as the MediCal application and language barriers. The application was conducted on the phone. The MediCal office has their own interpreters, so the F family was not comfortable with their system and preferred Mama Dee. Further, the appointment system wasn't community friendly. The appointment for MediCal that was given was in a time window between 8:00am-5:00pm which meant the family and Mama Dee had to standby for the whole day until the call was complete. Finally, the family shared their fears and worries regarding their immigration

status, so Mamadee spent additional time with the family to break down those fears and hesitancies.

ECSMC's challenges like so many organizations during the pandemic was short staffed due to the loss of one case worker who found full-time employment. There were occasions that required more time to engage as deeper issues surfaced. Due to COVID, staff began setting appointments in order to reduce the number of clients waiting for services and that became a better solution for time and private space needed to engage and provide a needed referral. A call to clients could be made for rescheduling most of the services if this time was needed.

CARIÑO PROJECT (COASTSIDE MULTICULTURAL WELLNESS)

The Cariño Project is funded 80% CSS, 20% PEI. The program opens pathways for increased services on the Coastside, limited in services. Counseling services include crisis counseling, family counseling, and counseling at schools, local churches and community spaces. Staff often use a home visiting model to serve families. ALAS is committed to meeting the client where they are, both emotionally and physically.

In FY 2021-22, the Cariño Project served 355 unique clients in San Mateo County through their clinical component (therapy and case management). 1,434 individuals (duplicated) were also engaged through various services including groups, training, arts activities and other supports.

The Cariño Project was founded on the opportunity to create new models of mental health and wellness wrap-around services that are grounded in cultural frameworks of intervention. The program opens pathways for increased services on the Coastside, limited in services. MHSA funding has allowed growth in programming and staff to increase wellness support services across the Coast. ALAS is centered on honoring the client and their cultural wealth. The program believes that each person and family is rooted in a history of tradition and culture that strengthens who they are, which should be honored and valued. Operating from a strengths-based and cultural wealth perspective, ALAS values each person, family, and child, embracing each person's identity, sexual orientation, race, ethnicity, and cultural background/s. The Cariño project strengthens opportunities to work closely with expanded community groups.

Program Impact

Cariño Project *	FY 2021-22
Clients served (unduplicated)	355
Cost per client	$1,016
Individuals reached (duplicated)	1435
Total Served	1790

** unduplicated clients served are individuals that received therapy and/or case management services, individuals reached includes the community at-large, families and others engaged through support groups, events, arts and other activities.*

Outcome Indicators

Domain	Indicators/Questions	#	%
General mental health	Due to this program, I am better able to cope with stressors in my life	9 of 13	69%
	Due to participating in this program, I have experienced an improvement in my overall mental health	7 of 13	54%
	Due to participating in this program, I have an improved ability to manage my mental health symptoms (clinical; follow-up/discharge)	45 of 50	90%
Self-Empowerment	Due to participating in this program, I am better able to support myself and/or my family (case management)	8 of 13	62%
Knowledge, Skills, and/or Abilities	Due to the Cariño Project, I learned something that is useful to me.	52 of 54	96%
Cultural Identity	Due to the Cariño Project, I feel more connected to my culture	52 of 54	96%
Connection and Support	Due to the Cariño Project, I feel more connected to my community	51 of 54	94%
Stigma Reduction	I feel more comfortable talking about mental health since I started attending Cariño Project counseling sessions	14 of 15	92%
	I feel more comfortable talking about mental health since I began participating in ALAS programs	4 of 11	36%

*****The development and implementation of the PEI Reporting Frameworks occurred late in the reporting period, so the data is not representative of the full reporting period.

Demographics

Age (N=93)	%	Gender Identity	%
Ages 0-15	10%	Female/Woman/Cisgender Woman	63%
Ages 16-25	12%	Male/Man/Cisgender Man	33%
Ages 26-39	26%	Genderqueer/Gender nonconforming	1%
Ages 40-59	42%	Unknown	1%
Ages 60+	10%	Decline to State	1%
Decline to State	1%	**Sexual Orientation**	**%**
Primary language	**%**	Straight or Heterosexual	90%
English	5%	Unknown	3%
Spanish	95%	Decline to State	7%
Race	**%**	**City/Region**	**%**

Asian/Asian American	1%	El Granada	1%
Black/African American	1%	Half Moon Bay	88%
Hispanic/Latinx/a/o	95%	Moss Beach	7%
White/Caucasian	1%	Pacifica	1%
More than one race	1%	San Mateo	1%
Unknown	1%	Unknown	2%
Decline to State	9%	**Disability/Learning difficulty**	**%**
Ethnicity	**%**	Chronic health condition	2%
Central American	8%	Physical/mobility disability	1%
Mexican/Chicanx/a/o	90%	Difficulty seeing	3%
Decline to State	2%	Mental disability	2%
		Multiple	1%
		No	91%

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals	0	0	0
Substance Use Disorders (SUD) Referrals	0	8	8
Other Mental Health (MH) Referrals	24	11	35
TOTAL	**24**	**19**	**43**

Referrals to Other Services

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	0	Legal	25
Financial/ Employment	0	Medical care	47
Food	29	Transportation	0
Form assistance	0	Health Insurance	106
Housing/ Shelter	0	Cultural, non-traditional care	0
Other	0	**TOTAL**	**207**

Program Narrative

ALAS is committed to finding the most vulnerable community spaces to create access for services using a culturally sensitive approach for services offered. The primary focus is working with the Latino community of the Coastside that has generally had limited services. The clients are 95 percent Latino

with the majority of them Spanish speaking or bilingual. ALAS works closely with individuals that navigate different immigration status, such as asylum seekers, mixed status families, Deferred Action for Childhood Arrivals (DACA), undocumented individuals, victims of crime and others. The work is centered on children, families, farmworkers, Latino Seniors and individuals. This past year ALAS has worked closely with an aging farmworker community, many who have received services for the first time. As a result of the MHSA funding, ALAS is working closely in the schools to serve children struggling from emotional and academic distress. Latino Seniors have also been another group ALAS has increased services to as the Cariño project allowed for a rich engagement with this population for resources and services. Children from birth and up are actively engaged in the program at all levels, to include high school. Mothers are another important part of the outreach along with fathers and caregivers as a whole. ALAS has the doors open to anyone that is interested in services.

ALAS' service model used is client-entered. ALAS follows all confidentiality guidelines as outlined by HIPAA. The work is rooted in a social justice model of counseling. For ALAS this is critical, since it is a small community. The work is centered on the trust of the community; thus, it is critical that culturally sensitive practices are used that recognize the culture of those that live on the Coastside. The service model is built on a framework of using the cultural arts as an entry point to provide wraparound services for each individual that comes to ALAS. The services are delivered from multi-culturally sensitive practices founded on care and concern for each client. The rights of the client are acknowledged to have the best treatment that honors the human rights and dignity of the individuals and families served.

The model developed on the Coastside is focused on four services areas that work in partnership with one another:

- Cultural Arts program - Ballet Folklorico, Mariachi, Drumming and Arts
- Education, to include weekly tutoring for the youth of the program
- Mental health and Immigration Case Management
- Community Engagement and Advocacy
- Farmworker Outreach

Cultural Arts

The arts programs of ALAS are generally the entry point into the program. The mission of using the cultural arts makes the program a safe space for families to come in the door. The sensory connection to the arts also makes the work significant in healing trauma in the youth served. Dancing, singing, playing, creating and drumming all are sensory practices wrapped in culture that strengthen the core of the child. Families are impacted by the arts as they connect them to their culture and create a bridge between parent and child. Three has been a unifying impact that the cultural arts have had on families in the program.

Another layer of wellness that is evident under ALAS's program is the leadership that rises out of the arts program- both by parents and youth. Community-driven participation, activism and ownership happens at the arts level in creating and developing events, leading community arts, and participating in visible civic events to perform and showcase the culture of the Latino community of the Coast. The work includes art workshops for youth, families, and the community.

Youth have risen as leaders in the Bay Area. At all levels, the leadership and service of youth is coupled with the direct involvement of the parents in the program. Parents and families take lead roles in the community arts programs that happen in ALAS. This work is increasing leadership and honoring the cultural wealth of the community.

Education

ALAS's education program directly responds to the wellness and mental health of the youth, infusing them with weekly tutoring to raise the bar of their learning. There has been story after story of youth raising reading levels, increasing test scores, passing state exams for reclassification and more. Every week the tutoring program happens in conjunction with the arts and case management program.

Mental Health and Immigration Case Management

The mental health component of the program is the heart of the work. The model exists as a wrap-around culturally sensitive model of practice that focuses on helping the family and/or individuals at all levels. ALAS provides services that focus on what the client needs.

Building on Maslow's Hierarchy of Needs ALAS is always aiming to focus first on the basic needs of families, reaching out to see how they are doing with issues of housing, rent, food and resources they need. In the work, staff advocate and connect them to additional County and local programs for services.

One of the most significant needs of the community is immigration support. Families on the Coast live in escalated fear of forced deportations and have few resources to help them cope or provide support during this critical time. ALAS focuses on being a safe space for the families to enter and identify needs that will support their well-being.

ALAS works with U-Visa victims and victims of crimes and provide counseling support for families with immigration crisis (including deportation of a parent). ALAS offers advocacy and case management to connect individuals to legal resources and grounds them in support throughout the process.

Counseling services include crisis counseling, family counseling, and counseling at schools, local churches and community spaces. Staff often use a home visiting model to serve families. ALAS is committed to meeting the client where they are, both emotionally and physically. Trust with the community has increased the referrals coming into the program and has expanded the need to grow and develop staff to meet the increased request for services.

Currently there is a waiting list for counseling services at ALAS. The needs for increased mental health in spaces such as Moonridge, Boys and Girls Club, Our Lady of the Pillar and at schools have increased, with referrals coming through ALAS. Given the demand for supporting the mental health and wellness of youth and families that normally do not qualify as seriously mentally ill has driven efforts to increase funding for mental health staff.

Community Engagement and Advocacy

ALAS's program of community engagement is grounded in the visibility of the work on the Coastside. ALAS believes to carry the responsibility to create spaces of equity for families where their voices can be heard. ALAS does this through showcasing the leadership of families and youth. ALAS also create

spaces of leadership where families can take the lead in community projects such as Dia de Los Muertos, La Posada, Noche en Mexico, Dia del Niño, and a local community Pumpkin Festival.

Families are involved in planning and organizing yearly events that ALAS sponsors for the community, including a Mariachi Serenata, Ballet Folklorico performances, and community celebrations. At each level of the work, the community of ALAS is part of the process, as community members take ownership in carrying out these events with great pride and detail. The work at ALAS has increased community-building and recognized the leadership of so many that were previously pushed away in silence. Rising out of the shadows, ALAS has put Latino families on the front stage of getting involved in the Coastal community at all levels of engagement.

The ALAS service model can be understood as a *temascal* (sweat lodge) of support. ALAS believes in creating a healing space where individuals, families and children feel at home. Bringing Mexico to so many that cannot go home represents an opportunity to connect to their childhood and culture. For those children born here, ALAS represents a bridge of connecting and strengthening their culture, improving self-esteem, identity and increasing leadership. The ALAS model has been presented nationally and has been recognized as leading the way in connecting culture to mental health using the arts as a sensory model.

THE PRIDE CENTER

The San Mateo County Pride Center (35% CSS, 65% PEI) creates a welcoming, safe, inclusive, and affirming space for individuals of all ages, sexual orientations, and gender identities through education, counseling, advocacy, and support. The Pride Center takes a holistic approach to improving the health and wellbeing of the LGBTQ+ community by providing direct mental health services to individuals living with severe mental health challenges and individuals in the community seeking support groups, resources, community building activities and social and educational programming.

Program Impact

(re)MIND *	FY 2021-22
Clients served (unduplicated)	169
Cost per client	$3,334
Individuals reached (duplicated)	4,456
Total Served	4625

** unduplicated clients served are individuals that received therapy and case management, individuals reached includes all other individuals that participated in peer groups, youth and older adult services, trainings, outreach and events.*

Outcome Indicators

Domain	Indicators/Questions	#	%
General mental health	CANS + ANSA* Depression subscales (Population: Therapy Services) - improved/ remained the same	41	85%
	CANS + ANSA Anxiety subscales (Population: Therapy Services) - improved/remained the same	26	54%
Improved knowledge, skills, and/or abilities	ANSA Interpersonal/Social Connectedness + CANS Interpersonal subscales (Population: Therapy Services) - improved/ remained the same	35	73%
Connection and Support	ANSA Natural Supports + CANS Community Connection subscales (Population: Therapy Services) - improved/ remained the same	36	75%

***The development and implementation of the PEI Reporting Frameworks occurred late in the reporting period.

Assessments are administered at intake and discharge, and at 6-month intervals during treatment. For this analysis, the two most recent responses within the reporting period (July 1, 2021-June 30, 2022) were compared. Comparative responses were available for 48 clients. Comparative data were not available for all therapy clients served. Clients who terminated less than 30 days after enrollment, and those who enrolled later during the reporting period only have 1 initial survey response (approximately 28 individuals). The CANS/ANSA assessments are also not required by the program for therapy group participants including the Kennedy Middle School Group and/or New Year Still Queer Asian, Asian American, or Pacific Islander (AAPI) – approximately 22 individuals.

- **CANS** (Child/Adolescent Needs and Strengths) Assessments (n = 9)
- **ANSA** (Adult Needs and Strengths) Assessments (n = 39)

The depression and anxiety subscales are considered “Needs” and scored between 0-3. A score of “0” indicates no need is present, whereas a “3” demonstrates high need. The interpersonal and natural supports subscales are considered “Strengths” and also scored between 0-3. For strengths, a score of “0” indicates a positive core strength and a score of “3” indicates no strength is identified.

On their most recent CANS/ANSA Assessments, Therapy clients:

- Depression: 35 out of 48 (about 73%) clients scored a “0” or “1”. A lower score indicates less of a need and/or no need. No clients scored a “3” which is the most severe need.
- Anxiety: 29 out of 48 (about 60%) clients scored a “0” or “1”. A lower score indicates less of a need and/or no need. No clients scored a “3” which is the most severe need.
- Interpersonal/Social Connectedness: 33 out of 48 (about 69%) clients scored a “0” or “1”. A lower score indicates a higher strength, which is a positive indicator.
- Community Connection + Natural Supports: 35 out of 48 (about 73%) clients scored a “0” or “1”. A lower score indicates a higher strength, which is a positive indicator.

CANS (n = 9)

DOMAIN	IMPROVED	%	SAME	%	WORSENED	%
Depression (Need)	1	11.11%	6	66.67%	2	22.22%
Anxiety (Need)	2	22.22%	6	66.67%	1	11.11%
Interpersonal (Strength)	1	11.11%	6	66.67%	2	22.22%
Natural Supports (Strength)	0	0.00%	6	66.67%	3	33.33%

ANSA (n = 39)

DOMAIN	IMPROVED	%	SAME	%	WORSENED	%
Depression (Need)	11	28.21%	23	58.97%	5	12.82%
Anxiety (Need)	8	20.51%	10	25.64%	21	53.85%
Interpersonal/Social Connectedness)	7	17.95%	21	53.85%	11	28.21%
Community Connection (Strength)	12	31.58%	18	46.15%	9	23.08%

CANS + ANSA combined (n = 48)

TOTALS (n = 48)	IMPROVED	%	SAME	%	WORSENED	%
Depression (CANS + ANSA, n = 48)	12	25.00%	29	60.42%	7	14.58%
Anxiety (CANS + ANSA, n = 48)	10	20.83%	16	33.33%	22	45.83%
Interpersonal (CANS) + Interpersonal/Social Connectedness (ANSA) n = 48	8	16.67%	27	56.25%	13	27.08%
Natural Supports (CANS, n = 9)	0	0.00%	6	66.67%	3	33.33%
Community Connection (ANSA, n = 39)	12	31.58%	18	46.15%	9	23.08%

A Mental Health Self-Assessment Survey is administered at intake and discharge, and at 6-month intervals during treatment. For this analysis, the two most recent responses within the reporting period (July 1, 2021-June 30, 2022) were compared. Comparative responses were available for 41 clients. Comparative data were not available for all therapy clients served. Clients who terminated less than 30 days after enrollment, and those who enrolled later during the reporting period only have 1 initial survey response (approximately 28 individuals). Follow-up responses were also not

readily available for those primarily enrolled in therapy groups (Kennedy Middle School Group and/or New Year Still Queer AAPI group: approximately 22 participants.

- Over 90% of therapy clients "Agree" or "Strongly Agree" that they have benefited from the Pride Center services they received.
- Over 70% of therapy clients rated their ability to cope with stress as "Good" or "Excellent".
    - Less than 3% rated their ability to cope with stress as "Poor"
- Over 63% of therapy clients rated their mental health as "Good" or "Excellent".
    - Less than 3% rated their mental health as "Poor"

1. How would you rate your mental health in the last 30 days? (n = 41)
    - Response options: Poor; Fair; Good; Excellent

Good or Excellent	26	63.41%
Fair	14	34.15%
Poor	1	2.44%

2. How would you rate your ability to cope with stress in the last 30 days? (n = 41)
    - Response options: Poor; Fair; Good; Excellent

Good or Excellent	29	70.73%
Fair	11	26.83%
Poor	1	2.44%

3. I have benefited from the services that I am receiving or participating in at the Pride Center. (n = 41)
    - Response options: Strongly Agree; Agree; Neutral; Disagree; Strongly Disagree

Strongly Agree	26	63.41%
Agree	11	26.83%
Neutral	3	7.32%
Disagree	0	0.00%
Strongly Disagree	1	2.44%

Demographics

Pride Center is currently working on a system to track non-clinical demographic data more effectively and accurately (e.g., peer group participants, older adult program participants, community event attendees etc.). Some ideas include using ETO (their electronic health record system). The demographic collection process has to be transparent, inclusive, and accessible. Asking community event attendees for demographic information may feel invasive and be a barrier for some.

Age (N=169)	%	Gender Identity	%
Ages 0-15	12%	Female/Woman/Cisgender Woman	21%
Ages 16-25	38%	Male/Man/Cisgender Man	13%
Ages 26-39	30%	Genderqueer/Gender nonconforming	13%
Ages 40-59	13%	Questioning or unsure	3%
Ages 60+	4%	Trans Man	25%
Decline to state	3%	Trans Woman	12%
Primary language	**%**	Another	4%
English	93%	Decline to state	8%
Decline to state	7%		
Race	**%**	**Sexual Orientation**	**%**
Asian/Asian American	21%	Asexual	3%
Black/African American	3%	Bisexual	11%
Hispanic/Latinx/a/o	15%	Gay or Lesbian	20%
Native American/ Indigenous	3%	Pan Sexual	8%
Native Hawaiian/Pacific Islander	1%	Queer	14%
White/Caucasian	36%	Straight or Heterosexual	11%
Another	2%	Questioning or unsure	13%
More than one race	6%	More than one	6%
Decline to State	13%	Decline to State	14%
Ethnicity	**%**	**City/Region**	**%**
African	3%	Atherton	1%
Chinese	8%	Belmont	2%
Central American	3%	Daly City	7%
Eastern European	3%	East Palo Alto	2%
European	21%	El Granada	2%
Filipinx/a/o	6%	Foster City	2%
Mexican/Chicanx/a/o	10%	Half Moon Bay	1%
Middle Eastern	2%	Hillsborough	1%
Vietnamese	1%	La Honda	1%
More than one ethnicity	15%	Menlo Park	2%
Another	8%	Pacifica	2%
Decline to State	20%	Redwood City	12%
Disability/Learning difficulty	**%**	San Bruno	2%
Chronic health condition	5%	San Carlos	3%
Difficulty seeing	2%	San Mateo	14%
Mental disability	17%	South San Francisco	6%
Another	5%	Woodside	1%
More than one	17%	Out-of-County	33%
No	29%	Decline to state	5%
Decline to state	25%		

Referrals

Pride Center is currently working on a system to track data more effectively and accurately on the referrals made. Currently, the clinical team members are asked to list any referrals they've made for their clients during the closing summary process when clients exit the program. However, the data for this FY 2021-22 report is limited. Pride Center is working on a system to collect information on type and number of referrals more regularly throughout treatment.

Program Narrative

Improves timely access and linkages for underserved populations
The Pride Center provides underserved and marginalized participants multiple avenues to access services and receive LGBTQ+ affirming treatment and connections to resources:

Functional One-Stop Shop and Resource Hub: The Pride Center is unique in that it offers not only direct mental health services, but also community-building social events, educational trainings/workshops, pathways to leadership and community empowerment, as well as direct access to resources and local service providers to improve the overall health and wellbeing of local LGBTQ+ individuals and the LGBTQ+ community countywide. At every facet of Pride Center programming there is an opportunity for individuals to learn more about and gain access to clinical services and resources.

Clinical Referrals: Within two business days of receiving referrals, Pride Center clinical staff will attempt to contact the referred individual to provide more information about case management and/or mental health services, assess any immediate needs the individual may have, provide resources and/or information as needed, and schedule a screening appointment. The Clinical Program Coordinator and Intake Coordinator assumes responsibility for managing incoming counseling inquiries. In coordination with the clinical team, staff are constantly working on the waitlist procedures to improve initial response times and decrease the amount of time it takes to get clients enrolled in services. The Clinical Program Coordinator also meets regularly with StarVista's Database Management team for continued process evaluation.

Prioritization of underserved and marginalized groups: As a whole, Pride Center staff have decided to prioritize services to underserved and undertreated individuals and members of high risk, marginalized, and otherwise vulnerable groups (e.g., non-heterosexual, non-cisgender members of the LGBTQ+ community, transgender and genderqueer/non-conforming/variant minorities, people of color, low-income individuals, victims of abuse, bullying, and/or crime, etc.). Low-fee and pro bono services have been offered to undocumented clients or those faced with financial hardship.

Meeting individuals where they're at: The Pride Center follows a client-centered approach. Treatment planning is done in collaboration with the client and goals are what the client themselves wants to work on rather than what the clinician thinks may benefit them. For example, if a client wants to work on reducing substance use but does not want to become abstinent, the clinician will utilize a harm-reduction focused approach to treatment rather than abstinence focused. Additionally, the clinical team makes efforts to work around potential barriers to care -- such as food access,

transportation, and housing status -- by assisting clients in navigating community resources through direct case management.

Reduces stigma and discrimination

The Clinical Component of the San Mateo County Pride Center reduces stigma and discrimination by:

- Organizing and participating in community and social events that foster positive representation of the LGBTQ+ community. Pride Center staff and programs directly reflect the diverse community and individuals served.
- Empowering vulnerable community members through mentorship, guidance, and psychoeducation around coping skills and strategies to help manage and overcome stressful circumstances.
- Educating LGBTQ+ families, both directly and indirectly through collaboration with the peer support workers, to increase families' acceptance, understanding, and support of their LGBTQ+ family members, reducing stigma and fostering a protective factor.

Increases number of individuals receiving public health services

- Many participants expressed that they engage with the Pride Center specifically because they know it is a safe and welcoming environment. Many are concerned about the quality of care and treatment they might receive from other providers due to their LGBTQ+ identity, as there is a pervasive fear due to a history of discrimination and mistreatment.
- The clinical team continues its outreach efforts to increase community engagement with the agency's psychotherapy and case management services. Outreach has included active participation in LGBTQ-specific Listservs such as Mind the Gap, Gaylesta and Bay Area Open Minds as well as building relationships with practitioners at other local agencies such as Communities Overcoming Relationship Abuse (CORA), the Felton Institute, and the Edison Gender Clinic, among others. The clinical team also continues to strengthen relationships with partner agencies. Referrals have been received from partner agencies, new agency connections, as well as Listserv postings.

Reduces disparities in access to care

The San Mateo County Pride Center is committed to providing mental health services to the LGBTQ+ community throughout San Mateo County. To reduce disparities in access to care, clinical services are prioritized to individuals who:

- Are members of marginalized and underserved communities
- Have untreated or undertreated behavioral needs, including mental health and/or substance-abuse related needs
- Have experienced emotional/behavioral disturbances over a prolonged period of time causing difficulty and distress in relationships at home, school, work and/or community.
- Are at high risk for increasing levels of severity of presenting issues without mental health intervention
- Are homeless or at risk of becoming homeless
- Lack safety due to domestic violence/abuse
- Are low income
- Experience isolation and/or social anxiety

- Demonstrate self-endangering behavior and/or history of suicide attempts or ideation
- Are victims of or witnesses to violent crimes (bullying, gun violence, domestic violence, etc.)
- Have difficulty managing anger and/or history of domestic violence perpetration

Whenever possible, Pride Center staff also provide resources and information to clients to help improve their access to services by reducing barriers preventing them from receiving the support they need. For example, some clients requesting services have not had access to a phone and/or suffer from severe agoraphobia (fear of leaving the house). Staff have provided county resources that provide no fee or low fee cell phones to these community members. Staff have also offered to meet clients in the field and have encouraged folks to make use of the Non-Emergency Medical Transportation benefit offered to Health Plan of San Mateo members, which is able to provide free transportation to eligible clients so that they can visit the Pride Center to receive clinical services. Similarly, encrypted, HIPAA compliant teletherapy services is utilized. This technology allows for clinical staff to provide essential services to clients who may be homebound or unable to physically visit the center (such as folks with chemical sensitivity issues or disabled individuals).

Implements recovery principles
Development of Positive Coping Skills **-** Clinicians utilize Cognitive Behavioral Therapy (CBT) as well as Seeking Safety interventions to help clients develop a broad spectrum of healthy coping skills tailored to their individual needs. Coping skills are practiced both in-session with the therapist as well as assigned as homework to help clients build new patterns of addressing stressful, potentially triggering scenarios.

Harm Reduction **-** When working with substance use, clinicians take a client-centered approach, meeting the client wherever they are in their recovery and following the client's goals. If a client does not want to cease substance use, clinicians utilize a harm-reduction approach to help the client decrease the likelihood of injury or overdose while using and help refer for higher level services if the need is indicated. Additionally, if the client's goal is to reduce their substance use rather than to be completely abstinence, clinicians will work with clients to support this goal.

Client-centered, Trauma-informed Approach **-** Treatment goals are client-centered, and treatment plans are created in session in collaboration with the client. The Pride Center does have a strict policy around the presence of substances on-site, which carried over into the telehealth platform for therapy services and is reliant on client's self-report. Clinicians also utilize Motivational Interviewing tailored to whichever stage of change clients are in. All clinical treatment is trauma-informed, starting with the initial assessment. Substance use is addressed along with present trauma-related symptoms, rather than treating dual diagnoses separately.

Successes

Overall: With the anti-LGBTQ+ legislation occurring across multiple states, the Pride Center was heavily leaned on for consultation on local proclamations, statewide legislation, and policies. Different team members played pivotal roles in supporting around issues for the ongoing pandemic, supporting reproductive rights and gender- affirming care, and assisting with MPX communication and messaging. The Pride Center established an ongoing relationship with county health and public

health officials, and the Office of the Governor. Similarly, staff helped respond to an unfortunate series of hate crimes on the Coastside region.

The Pride Center continues to increase and solidify the work with community partnerships and collaborations throughout the county. Continued investments have been made in staff professional development with ongoing internal training opportunities. These skills-building workshops included de-escalation training, a 2-part disabilities awareness series, LGBTQ+ Intimate Partner Violence, and more. Working with StarVista Facilities Operations Coordinator strategic investments were made in the physical space of the Pride Center itself. The layout of the center is now more physically accessibly, has been upgraded with COVID safety in mind, and updated with hybrid technology.

Clinical*:* As of July 2022, the Legal Name and Gender Change Workshop has served 310 individuals and each month the Lead Case Manager and Case Management Intern continually learn how to support clients in new and unique situations.

Sponsored by a grant from Kaiser Permanent Northern California Community Benefit Programs, the Health Equity Coordinator and case management interns, alongside the Program Director and Lead Trainer and Events Coordinator, successfully launched the Resource Roadmap campaign to support transgender, gender diverse, and non-binary individuals. These trainings covered a range of topics, starting with interactive exercises to challenge biases and assumptions that impact the work with Transgender and Non-Binary, plus others (TGNB+) folks; identifying gender-affirming providers for housing, healthcare, employment, and legal sectors; and sharing valuable tips and best-practices to best support TGNB+ clients in navigating the resources they may need. Both trainings were well received and garnered much interest from the network of community partners! Another component of the Resource Roadmap was the creation and distribution of a series of invaluable resource brochures intended to serve as tools and guides to help empower TGNB+ individuals in navigating various resources in San Mateo County and beyond. For more details and the brochure collection, please visit: https://sanmateopride.org/resource-roadmap.

Resource Roadmap – Service Provider Training feedback

- *"…having a chance to speak to an expert is amazingly helpful! Additionally, the two presenters are very knowledgeable, approachable, and were very good at easing the tension. Facing your own biases is not always easy but they made it easier for sure. Y'all are doing great work!"*
- *"I enjoyed the survey questions. I learned new terms and got a better understanding of the different terms… I have 2 LGBTQ residents and have helped them with mental health, job search, and emotional support. This gives me a stronger foundation to continue to help and support our residents. Thank you so much!!"*
- *"The resources and supporting staff in changing their forms/procedures/etc. to be more inclusive in ways we may have never considered."*
- *"The information was well presented and engaging. Everyone should take this training."*

New Year; Still Queer Therapy Group: A space for Queer AAPI health professionals and activists. The Pride Center collaborated with an outside provider to co-facilitate an 8-week therapy process group for queer AAPI folks in March through April 2022. The idea for this group was at least in part developed in response to COVID-19 related rise in Anti-Asian hate crimes. The group averaged 10 participants each week. Every participant received a free mental health journal kit, which were

donated by the sponsors for the event. Topics discussed and processed included (but was not limited to): racism, microaggressions, discrimination, sense of belonging, intersectional identity, self-care, boundaries, and community building. Throughout the development of this project, two grants have been secured that helped fully fund this group including being able to provide the space for the community free of charge.

LGBTQ+ grief group: The Pride Center, in collaboration with Mission Hospice, held an LGBTQ+ grief group. This weekly 90-minute group ran for 8 consecutive weeks and discussed topics such as 'legacy', 'intersectionality', 'LGBTQ+ stigma', and 'hope'. Group members who attended stated that there was a lack of LGBTQ+-affirmative resources around grief and loss in San Mateo County. Also, the group members who attended that lost a partner shared that they felt especially seen, heard, and validated with this space. This group was free of charge.

Client Testimony: *"The Pride Center has been very helpful in building self-esteem, affirming my efforts during COVID and in-general and helping me learn computer literacy skills and directing me to resources that are available in the community."*

Youth Program: The training program resumed in-person services which allowed for an increase in the number of folks who have been educated on SOGIE 101 topics. Similarly, the outreach has increased due to resuming in-person events. The Pride Center has continued to be able to serve the LGBTQIA+ youth community and their support systems both online and in-person based on individual needs.

Training/Education Program*:* Their continues to be a growth in requests for SOGIE trainings, and more interest in specialized trainings (Pronouns 101 and Trans 101). There has also been a subtle increase in previous organizations requesting multiple rounds of trainings to maximize their staff engagement with the Pride Center's educational services. Overall, positive feedback was received about trainings, including a community member stating*, "I have 2 LGBTQ residents and have helped them with mental health, job search, and emotional support. This gives me a stronger foundation to continue to help and support our residents. Thank you so much!!".*

Community Events*:* There has been many community members that enjoy the digital events and programs offered. From successful intergenerational dinners to celebrating the Pride Center's 5-year anniversary, the community has continued to show up and be present for all that the center has to offer. One community member who attended the virtual 5-year anniversary celebration stated, *"The event was hosted by a remarkable member of the Pride Community, Jesus!!!! and we heard from the history of the Pride Center, Jei Africa, Lisa Putkey, etc. and all through the Pride Center's evolution to June 30, 2022!"*. This year, the Community Advisory Board (CAB) shifted its focus to supporting the most prioritized need for the center. The 5-year anniversary event would not have succeeded without the planning support of the CAB members.

Development: The fundraising initiatives of the Pride Center were successful in unexpected yet welcomed ways which spoke to the true community spirit which inform both the philosophy and the practices of the programs and services. Working with StarVista, $55,000 was raised from grants and foundations one of which included an opportunity from the Kaiser Foundation. This has solidified a budding relationship for ongoing and future grants in the hopes of securing another multi-year foundational grant. A total of $27,500 was collected from individual donations and sponsorships. This

total amount of donations included the amount raised through the 5-year Pride Center Celebration which raised over $2,000 in just one evening! Lastly, it's with great importance and acknowledgement that thanks to the commitment of San Mateo County's BHRS Office of Diversity and Equity, local government support, and allies, the Pride Center is more financially secure than ever before. This success is not to be named alone, but the work of the community who has supported since the beginning. Thank you with pride, from Pride.

Challenges

Overall: The greatest challenge this year was the Administrative Coordinator position being vacant for approximately 8 months. This position plays a critical role in supporting the general operations of the center, the leadership, and assists with website and data management. The extended absence of this position was felt across several team members including the Program Director, the Marketing and Community Engagement Lead, the Clinical Program Coordinator, and the role of the Clinical Program Analyst. Additional team members such as the Lead Trainer and Events Coordinator, Peer Group and Volunteer Coordinator, and one of the Mental Health Clinicians as well the Program Director all had to assume some of this position's responsibilities. However, there were still negative impacts felt by clients and community members especially when it came to external communications.

Clinical Program: There is considerable challenge around hiring a Spanish bilingual mental health clinician (Associate-level). A few applicants have been received and those who did apply often did not meet the minimum qualifications. It is suspected that the low number of applicants may also be due to the job opening being limited in hours available and relatively low pay for a bilingual mental health clinician. There have also been challenges around coordinating the publication and promotion of the job posting. As a solution, the Clinical Program Coordinator will be re-evaluating the marketing and outreach strategy and will work closely with StarVista administrators to explore other avenues of recruitment. Limitations to hours offered and relatively low pay is expected to remain an ongoing challenge.

There have been considerable administrative and bureaucratic challenges that have significantly delayed the start of the Kennedy Middle School LGBTQ+ student therapy group. Typically, the group begins in the Fall; however, this school year it started in March 2022. One of the challenges has been the turnover of staff at the school district that has resulted in unexpected inconsistencies in communication. The clinical program coordinator will ensure an earlier start in communication with the school district next schoolyear to help prevent future delays.

Decrease in programmatic support due to StarVista staff turnover has posed several challenges in the areas of data reporting, data streamlining efforts, and ability to provide consistent trainings to the clinical trainees. These issues are expected to resolve as StarVista administrators restructure and/or bring on new staff.

Clients continue to report challenges around access to care; and for providers, care coordination would also be much easier if in-person resources and connections were available and accessible.

Due to the COVID-19 pandemic, the clinical staff continues largely with a telehealth approach in providing effective clinical services for clients. Most clinical staff continue to work remotely from home using Zoom and Microsoft Teams for clinical sessions. With limited in-person services, this

poses a challenge for some clients, who might not have access to the necessary technology or means to use telehealth. Older adult clients might also not be as familiar with how to utilize the technology.

A number of clients continue to have challenges with creating safe boundaries with family members due to spending considerably more time at home. Not all safe LGBTQ+-affirming community spaces have opened to the public for gathering in-person. Increased distress is expressed when living with homophobic and/or transphobic family members.

Several clients have expressed gratitude for being able to do therapy sessions via telehealth. Many clients do not have reliable transportation, so attending therapy services in-person at the Pride Center would create challenges for them.

Development: The challenges by the vacancy of the Administrative Coordinator position was felt with the development portfolio as well. The Program Director worked with consultants to redesign the online store options, especially in the name of visibility considering the anti-LGBTQ+ hate legislation surfacing across the United States. The Program Director and Marketing and Community Engagement Lead along with other team members also completed critical work to develop, market, and get ready to promote and monthly donor campaign for the Pride Center to better support ongoing funding initiatives. However, due to capacity issues related to reduced marketing capacity and having no additional people to support with website management, e-blasts, newsletters, daily programming, special events announcements, peer group promotions and changes, etc., there was not enough time or capacity to promote either new initiative.

GiveOUT month in June 2022 was not capitalized. With supporting the 10-year San Mateo County Pride Celebration, coordinating the Pride Center's 5-year celebration, the Program Director managing the fiscal year budget, and the marketing person too stressed managing their regular duties, there was no ability to take on the extra fundraising chance despite the copy/text already been written. It was a heart-breaking decision to make.

Youth Program: the creation of new social groups has proved tricky with groups continuing to meet online. There is hope that there will be the ability to establish more visibility of these groups through community partners and (eventually) in-person meetings.

Trainings/Education Program*:* Engagement with training/education activities can be stifled because of the online learning platform. Despite efforts to adapt the trainings to be virtually engaging, there is recognition of the need for in-person education. Thus, this new fiscal year, there will be the options of either, virtual, in-person, or hybrid trainings to accommodate to the need for dynamic training styles to meet the needs of community organizations and their staff.

Community Events: With safety precautions around COVID still impacting the ability to host in person events, the person-to person engagement at the center is missed. However, this does not hinder the ability to collaborate with organizations, such as the Pride Initiative, to bring community members to other in-person events. As a result of the deeply rooted connections, planning for the first in-person San Mateo County Pride Celebration was supported since the pandemic for its 10-year anniversary. This event garnered the participation of over 1000 community members.

PEER COUNSELING PROGRAM

The Peer Counseling Program (PCP), formerly Senior Peer Counseling, from the Peninsula Family Service (50% CSS, 50% PEI) is comprised of specially-trained volunteer counselors, more than 100 in total, to provide weekly visits to older adults to help manage transitions and life changes such as health concerns, mobility issues, caregiver needs, and grief. Special care is taken to connect participants with someone who shares similar life-experiences and perspectives, with support offered in languages such as English, Mandarin, Cantonese, Spanish, and Tagalog, and to participants who identify as LGBTQ+. Peer Counseling provides peer support by trained and supervised older adult volunteers. The program serves older adults, 55 years and older, who reside in San Mateo County who are isolated, depressed, and anxious. The program targets underserved older adult population who may be monolingual in Spanish, Mandarin, Cantonese, Tagalog and to participants who identify as LGBTQ+.

Peer Counseling provides 35 hour training, in-services and monthly clinical supervision to peer volunteers. These volunteers provide weekly one on one or group peer counseling to participants throughout San Mateo County. They also link participants to needed resources in the community. Once background checks are complete, the volunteer is matched with at least one participant and they meet on a weekly basis via phone, Zoom or in-person meeting. The peer counselor's goal is to provide emotional support and connect the participant to needed resources. Trained peer counselors also provide weekly drop-in group support in Let's Talk Groups which are also held in person or via Zoom throughout San Mateo County.

Program Impact

Peer Counseling	FY 2021-22
Total clients served	539
Total cost per client	$637

Outcome Indicators

Domain	Indicators/Questions	#	%
Stigma Reduction	Reduced stigma in talking about difficulties in life- "How does talking with your counselor/groups affect your well-being"	28	46.7%
	Reduced stigma in reaching out for support- "what support did you need/get from other peers?"	27	45%
Improved knowledge, skills, and/or abilities	"what knowledge or skills did you learn from the program	12	20%
	Increased knowledge/access to services		
	"How is this program helping you improve your knowledge/access to the services in the community?"	8	13.3%

Connection and Support	Increased community connection and support "What community connection and support you received from this program?"	14	23.3%
	Improved General mental health "How is this program helping you with your mental health needs?"	17	28.3%

*****The development and implementation of the PEI Reporting Frameworks occurred late in the reporting period.

This evaluation sought to understand the impact of the Peer Counseling Program on the beneficiaries – one-on-one and group participants – and to identify program areas that need improvement. Although those who participated in the feedback gathering were not representative of all program participants, the information gathered does contain useful insights that will inform decisions.

Overall, PCP participants expressed their appreciation of being part of the Peer Counseling Program. They also seize the opportunity to thank Peninsula Family Service for offering such a wonderful service and for going the extra mile to maintain services despite the challenges brought upon us by the COVID-19 pandemic. They provided feedback on their experience with the program and suggested ideas for its improvement. It is important for PCP to look closely at how best to reach out to more older adults in the community, expand relevant service options, and assist participant expand access to community resources and building connections.

Demographics

Age (N=171)	%	Gender Identity	%
Ages 40-59	2%	Female/Woman/Cisgender Woman	80%
Ages 60+	93%	Male/Man/Cisgender Man	17%
Unknown	5%	Unknown	4%
Primary language	**%**	**City/Region**	**%**
English	52%	Belmont	2%
Spanish	23%	Burlingame	4%
Cantonese	5%	Daly City	14%
Chinese	2%	East Palo Alto	1%
Mandarin	10%	Foster City	4%
Japanese	1%	Half Moon Bay	7%
Tagalog	3%	Menlo Park	4%
Unknown	4%	Millbrae	3%
Ethnicity	**%**	Moss Beach	1%
Asian	2%	Pacifica	6%
Asian Indian/South Asian	2%	Palo Alto	2%
Black / African American	1%	Redwood City	13%

Central American	2%	San Bruno	4%
Chinese	16%	San Carlos	2%
Fijian	1%	San Mateo	29%
Filipino	5%	South San Francisco	5%
Hispanic/Latino	16%	Unknown	1%
Japanese	4%		
Mexican/Chicanx/a/o	5%		
Puerto Rican	1%		
South American	3%		
White / Caucasian	38%		
Another	1%		
More than one	3%		

Referrals

Mental Health and Substance Use Referrals

Types of Referrals	FY # Referrals to programs within your agency	FY # Referrals to other agencies	FY Total #
Serious Mental Illness (SMI) Referrals	0	7	7
Substance Use Disorders (SUD) Referrals	0	3	3
Other Mental Health (MH) Referrals	0	2	2
TOTAL	**0**	**12**	**12**

List of programs/treatment referred to (aggregate information, not individual):

- San Mateo county mental health clinic
- San Mateo County Behavioral Health and Recovery Services
- KARA – grief support
- ACCESS –mental health support

Referrals to Other Services

Types of Referrals	FY Total #	Types of Referrals	FY Total #
Emergency/ Protective services	5	Legal	11
Financial/ Employment	6	Medical care	26
Food	29	Transportation	51
Form assistance	15	Health Insurance	11
Housing/ Shelter	53	Cultural, non-traditional care	12
Other	0	**TOTAL**	**248**

Program Narrative

Peninsula Family Service conducts an annual program evaluation to determine if the program is meeting the established goals and to determine where improvements can be made. Program participants and peer volunteers complete either an online, paper or phone interview survey. The survey is available in English, Spanish and Mandarin. A copy of the most recent survey results is attached. Some of the highlights from the FY 2021-22 survey were:

- 89% of the volunteers were satisfied with the program
- 86% of the participants said the program was very valuable to them
- 89% of the volunteers who responded to the survey said that training on meeting the needs of the participants was great. “We learn from others, and it benefits us”. “I thought the initial training was terrific and the staff is always available for questions”.

The Peer Counseling Program is a program that is preventative. When a participant needs a higher level of care, program staff make a referral to an appropriate resource. Volunteers attend monthly clinical supervision where they receive oversight and guidance in working with their clients. In supervision, Peer Counselors discuss clients who may be suicidal, at risk of homelessness, abuse or neglect. Referrals are made to the proper resource and follow ups are conducted to make sure the resource was accessed.

Improves timely access and linkages for underserved populations: Program referrals are received via phone, in-person, or secure fax. The Program Director may contact the participants or the referral source for more information or determine program suitability. Once determined appropriate, the Director will send the referral to the peer counseling Coordinators to find a match peer counselor. The program Coordinators speak Spanish, Mandarin, Tagalog, English and are from the LGBT+ population. Coordinators will contact their volunteers to find a match. If a match is not found, the Director keeps the referred participant on a waiting list and reviews it monthly. Groups are offered in the community, at older adult housing, the Pride Center, community centers, etc. The groups are currently held on Zoom, so participants county-wide may join any group. When a new participant joins a group, an intake is completed.

Reduces stigma and discrimination: Many older adults have a stigma about receiving mental health support from a licensed provider and find that talking to someone who has lived through similar experiences, share a similar age, or share a similar culture does not have the same stigma. Because of stigma, the support groups are not called counseling groups; they are instead called Let’s Talk, Platica, or Kapihan. Platica in Spanish means Chating, and Kapihan means getting together for coffee and chatting.

Increases number of individuals receiving public health services: Peer Counselors refer participants to public health services when appropriate.

Reduces disparities in access to care: The Peer Counseling Program is free and available to all San Mateo County residents, 55 years and older, who can benefit from the program. Those who need a higher level of care are referred to other resources.

Implements recovery principles: Many peer counselors help participants establish goals to become less isolated, lonely, or anxious.

Successes

Peer Counseling conducted one Zoom English-speaking training and one Zoom Spanish-speaking training during the program year. Peer Counseling was successful in once again using the Zoom platform to train safely and successfully. The volunteers remained engaged throughout the training. During the year Peer Counseling brought in 17 new peer counselors and there are currently 91 active peer counselors. Peer Counseling continues to hold monthly clinical supervision groups and in-service trainings by Zoom and many of the volunteers want to continue meeting this way in the future so that they save time that it would take to travel to the meeting, they don't have to pay for parking, and they save on gasoline. In-service topics covered this year include:

- Introduction to the Wysa App and Zoom Tips review
- Setting Boundaries with participants
- Understanding Dementia
- Trauma and Aging
- Fall prevention with Stanford Healthcare
- Villages of the Coastside
- Memoir Writing
- Center for Independence for Individuals with Disabilities
- Parkinson 's disease and Mobility-Rock Steady Boxing

One of the newest Let's Talk Groups that Peer Counseling has developed is the Let's Talk at Teatime which started in April. The group facilitator volunteer, Surinder Batra, runs a weekly Zoom support group for older adults who identify as Asian Indian. The group is well attended and creates a supportive community for this growing population of older adults in San Mateo County. There are now 24 active support groups in San Mateo County.

An emergency needs for instructions for using food stamps in 2020 led Louise to call the Older Adult Resource Line. She also was matched with Joyce, one of the peer counselors, who provided weekly calls of support as Louise isolated herself in her mobile home in East Palo Alto during the pandemic. The two bonded and navigated Louise's complicated health issues and her estrangement from her family. Sadly, Louise's breast cancer returned for the third time this spring. With no family at her deathbed in a skilled nursing facility, Joyce was there to hold Louise's hand as she passed away.

Challenges

It has been challenging to recruit large numbers of volunteers during COVID. Peer Counseling usually has great results from marketing the program at community fairs, but this year there was a lack of opportunities to recruit at community events. This summer some outreach activities were implemented and recruitment of some volunteers for the next training. Peer Counseling was only able to hold two trainings for new volunteers during the FY 2021-22 due to the loss of two vital

positions, the Peer Counseling Director and the LGBTQ Coordinator positions, and Peer Counseling was unable to fill the position until June 2022. While the positions were vacant the Vice President of Older Adult Services stepped in to operate the program on a daily basis and staff pitched in to help.

Lastly, collecting monthly visit forms and other documentation has been difficult to attain as a result of having virtual supervision group meeting. In May Peer Counseling started asking volunteers to submit their hours and referrals to other resources via Survey Monkey. For some of the volunteers using Survey Monkey has been challenging. Staff have provided hours of training to support the volunteers and are finally starting to see great results.

WORKFORCE EDUCATION & TRAINING (WET)

WORKFORCE EDUCATION AND TRAINING (WET)

Workforce Education and Training (WET) exists to develop a diverse workforce. Clients and families/caregivers are trained to help others by providing skills to promote wellness and other positive mental health outcomes, they are able to work collaboratively to deliver client-and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers. As part of the mission of the Office of Diversity and Equity, which is "…in collaboration with and for community members, the Office of Diversity and Equity (ODE) advances health equity in behavioral health outcomes of marginalized communities throughout San Mateo county; the WET Team, informed by broader social justice and equity efforts, a wellness and recovery orientation and two advisory committees, strives to equip the workforce, consumers, and family members for system transformation by planning, coordinating, and implementing a range of initiatives, trainings, and program activities for the BHRS workforce, consumers/family members, and community partners.

There are several distinct populations served directly by the WET Team. The BHRS Workforce, people contracted by San Mateo County to provide behavioral health services, consumers and family members and subgroups of those populations actively participate in the program activities. For example, WET program areas such as the BHRS Clinical Internship/ODE Internship programs are implemented for Interns and other non-licensed/certified staff/community providers to gain knowledge and supervised professional experience in a local government setting. One of the broader objectives of the internship programs is to attract and retain a diverse workforce to better serve the San Mateo County communities.

As a program area of ODE, the WET Team also focuses on providing program activities that are in alignment with the best practices established by ODE and policies implemented by the County and this includes modeling the ODE Team values across the work. For instance, pronouns are disclosed when introducing ourselves at trainings and meetings. The WET Team program areas may be categorized into three broad areas. Training and Technical Assistance, Behavioral Health Career Pathways and WET Workplace Enhancement Projects. The annual training plan and education sessions to provide up-to-date information on practices, policies and interventions approved for use in BHRS is an integral component of the Training and Technical Assistance area. Interns who have obtained an internship in one of the more than 20 clinic and program training sites can collaborate with the County's Health Equity Initiatives in the Cultural Stipend Internship Program which is supported by the Behavior Health Career Pathways program area. As part of the BHRS Workforce Enhancement Projects, the WET team was actively involved in the successful, inaugural BHRS Mentorship Program.

Program Impact

The WET Team of the Office of Diversity and Equity provides programs that build the capacity of the workforce, community providers, and consumers and family members. Primarily providing training/education/development. It is imperative for underserved, marginalized community members and populations to have timely access and links to services, in their many forms provided by the county. Those communities include ethnic/racial communities, communities' members with limited English proficiency and member of the LGBTQ communities. However, there are sometimes barriers which may hinder the timely access. Some of those barriers might include lack of language services, lack of cultural humility, lack of knowledge of trauma informed care practices and/or recovery as a lifestyle. WET activities help to reduce stigma and discrimination by training providers, community members. Most workforce education activities have an indirect impact however, without it, members of the community may suffer lack of access to services or insufficient services. By attending some events as a constant presence, trust is built, and communities are more likely to reach out when they or someone they know may need of services. Equity is a core principle in WET trainings.

Total number of WET Implemented/Supported trainings: 50

- Total number of Attendees: 982
- Total number of ASIST/Suicide Prevention Trainings: 0 (Living works only allowed for in-person training, which was not possible during FY 2021-22.
- Total number of Cultural Humility/Working with Interpreters/SOGI: 25 (including Training of Trainers)
- Total number of For/By Consumers and Family Members: 2 (Be Sensitive Be Brave)
- Total number of AOD/Integrated Behavioral Health: 4
- Total number of Health Disparities Trainings: 20
- Other**: 16 (New Implicit Bias Trainings)

*Many trainings are open to consumers and family members. Many consumers and family members attend the training that are not directly for or provided by them.

**Other trainings include, ABC's of Child Family Treatment(CFT), Crisis Response Team, (Clinical)Supervisors' Training, Internship orientation, Photovoice, BHRS New Hire Orientation, Prevention and Management of Assaultive Behavior, Child and Adolescent Needs and Strengths (CANS) Training, and Law and Ethics for Behavioral Health Providers.

In the 2021-2022 fiscal year the WET team was able to successfully continue the implementation of virtual trainings as a response to the COVID-19 pandemic in addition to reintroducing in-person trainings. One of the main continued initiatives for the 2021-2022 fiscal year was to implement the Relias Behavioral Health Library Solutions supplement to the San Mateo County LMS in order to extend and expand online courses/trainings for all BHRS staff and providers. The WET team has continued to strengthen the collaboration with AOD services to structure their service plan for staff members. The team also successfully supported April provider wellness month with deputy directory Xiomara Ochoa through 30 events with over 500 participants.

The 2021-2022 cohort of Cultural Stipend Interns produced great outcomes in a multitude of unique projects. The projects were completed by 6 interns by supporting one of 9 Health Equity Initiatives. These projects included:

- African American Community Initiative: "BETA" Black Empowerment Through Awareness; community outreach project, intern facilitated workshop during Black History Month Celebration to assist in promoting black wellness and recovery
- Filipino Mental Health Initiative: Growth for a Cafe; Assistance in building up school-to-career/youth development through a Social Enterprise Cultural Center and Cafe by networking with community, surveying the community needs, and how to bring that into reality.
- Latino Collaborative: ACE's use among Latinx Children; research paper on how Adverse Childhood Experiences should be utilized when assessing children of the LC community within the juvenile justice system
- Native and Indigenous Peoples Initiative: Knowledge is Power; Facilitated a workshop for clinicians at placement focused on efficient ways to provide services to the NIPI community, while also providing a local history of Native Peoples from San Mateo County, and acknowledging the stigmas
- PRIDE: SOGI research ;research based project, understanding the barriers, advantages, and what the next steps for BHRS should be with SOGI.
- Spirituality Initiative: Spirituality Survey; Collect data to assess treatment and holistic perspective that incorporates spirituality as a form of therapeutic interventions.

Challenges

One of the greatest and most consistent challenges to implementing WET program activities due to the continued impact of the COVID-19 pandemic along with the inability to provide ASSIST trainings due to lack of permission provided by contractor for virtual trainings. Additionally, the loss of staff contributed to hurdles faced during the 21-22 fiscal year.

HOUSING

HOUSING

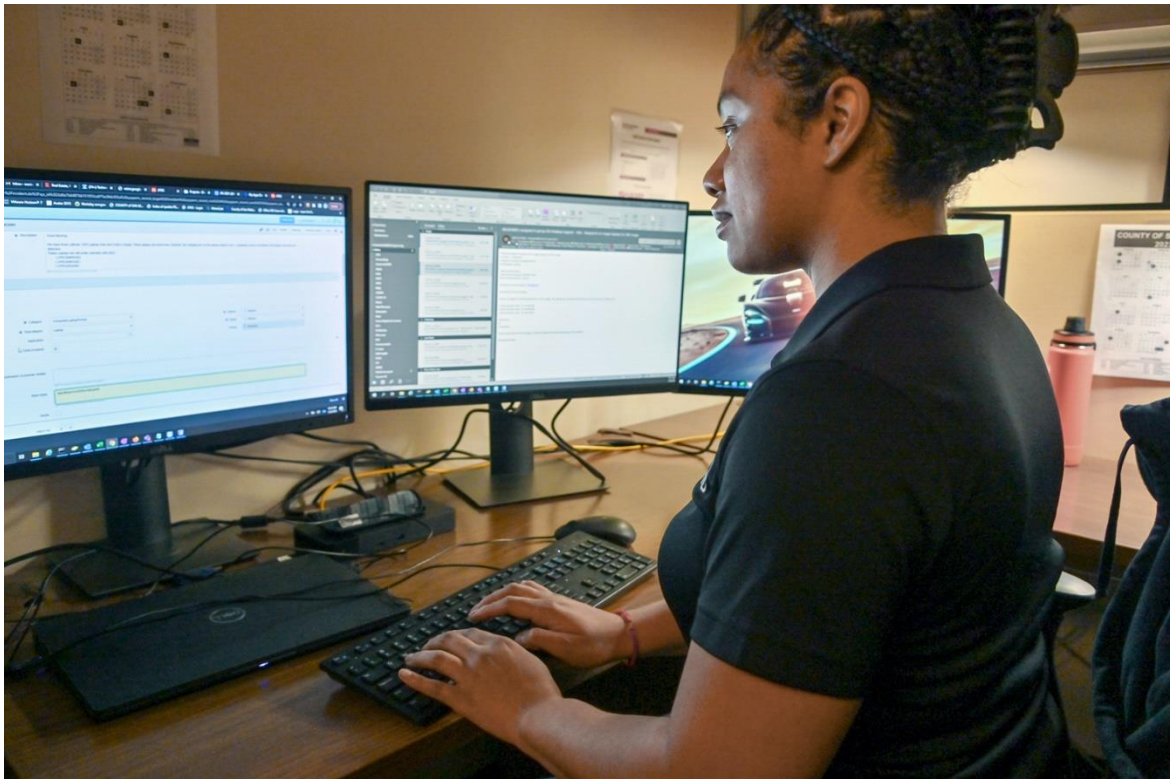
MHSA Housing funds provide permanent supportive housing through a program administered by the California Housing Finance Agency (CalHFA) to individuals who are eligible for MHSA services and meet eligibility criteria as homeless or at-risk of being homeless. BHRS collaborated with the Department of Housing and the Human Services Agency's Shelter Services Division (HOPE Plan staff) to plan and implement the MHSA Housing program in the County.

The MHSA Housing Taskforce Recommendations from May 2021 included the allocation $10M to develop supportive housing units as part of the local Department of Housing Affordable Housing Funds (AHF) Projects. It was estimated that the County could develop about 24 units per $5M contribution. Two separate Notices of Funding Availability (NOFA) have gone out in the Summer of 2021 and 2022 to select the housing project developers.

- Year 1 – 25 MHSA units in East Palo Alto, North Fair Oaks and South San Francisco
- Year 2 – 25 MHSA units in Redwood City and Daly City

As part of the Strategy Recommendations from the Community Program Planning process for this MHSA Three-Year Plan is the development of supportive housing slots for individuals living with mental health and substance use challenges that do not require homelessness as an eligibility requirement. This is something to be explored as investments in housing developments continue.

Year	Housing Development and Location	Units
2009	Cedar Street Apartments 104 Cedar St., Redwood City	14 MHSA units 14 total units
2010	El Camino Apartments 636 El Camino Real, South San Francisco	20 MHSA units 106 total units
2011	Delaware Pacific Apartments 1990 S. Delaware St., San Mateo	10 MHSA units 60 total units
2017	Waverly Place Apartments 105 Fifth Ave, North Fair Oaks	15 MHSA units 16 total units
2019	Bradford Senior Housing 707-777 Bradford Street, Redwood City	6 MHSA units 177 total units
2019	2821 El Camino Real, North Fair Oaks	6 MHSA units 67 total units
TBD	AHF NOFA 9.0 and AHF NOFA 10.0	50 MHSA units
		121 Total MHSA Units



CAPITAL FACILITIES & TECHNOLOGY NEEDS(CFTN)

E-CLINICAL CARE

San Mateo County has had no viable opportunities under the Capital Facilities section of this component due to the fact that the guidelines limit use of these funds only to County owned and operated facilities. Virtually all of San Mateo's behavioral health facilities are not owned but leased by the County, and a considerable portion of services are delivered in partnership with community-based organizations.

Through a robust stakeholder process it was decided to focus all resources of this component to fund eClinical Care, an integrated business and clinical information system (electronic health record) as well as ongoing technical support. The system continues to be improved and expanded in order to help BHRS better serve the clients and families of the San Mateo County behavioral health stakeholder community.

During the pandemic, devices (phones, tablets) and data plans were provided to BHRS clients to support their engagement with telehealth and other online supports, as part of a one-year one-time funding. Starting in FY 2021-22, stakeholders prioritized the continuation of the program. MHSA now funds the ongoing procurement of devices with data plans for BHRS clients. Additionally, basic technology supports for clients are provided via a virtual and/or over-the-phone IT Ticket System and digital literacy training for peer staff through a contract with Painted Brain, a peer run organization with technology expertise.

$330,000 per year is allocated to CFTN ongoing for client devices and data plans. A part-time peer worker was recently hired to support device distribution and training plan, and this would include improved tracking, data collection and reporting on the projects impact as it relates to improving client engagement in behavioral health and recovery services.

APPENDIX 1. MHSA THREE-YEAR PLAN 30-DAY PUBLIC COMMENTS RECEIVED

APPENDIX 2. MHSA THREE-YEAR PLAN WORKGROUP MATERIALS & FACILITATOR GUIDE

MHSA Three-Year Plan Workgroup

Meeting 1: November 10, 2022

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Welcome & Agenda

1. Introductions (10 min)
2. Workgroup Objectives & Expectations (5 min)
3. MHSA Community Program Planning (CPP) Overview (10min)
4. Phase I: Needs Assessment (60min)

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Workgroup Objectives

- Goal: Co-design, and implement an MHSA 3- Year Plan Community Program Planning (CPP) process that is equitable, inclusive and honors and centers the voices of marginalized communities.
- Meeting Objectives:
  1. Needs Assessment - review and advise on data needed to support a comprehensive needs assessment
  2. Strategy Development - advise on the community input process and community engagement best practices, to ensure it is inclusive of all vulnerable communities
  3. Input Sessions - Support opportunities for all San Mateo County community members to provide input

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Participation Expectations

- Participation in all 3 scheduled meetings
- Completion of any homework assigned in between meetings by the deadline stated
- Be present, provide your input, stepping up and back
- Be brief and meaningful when voicing your opinion
- Practice both/and thinking; consider all ideas along with your personal interests

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

About MHSA

76% **Community Services & Supports (CSS)**
Direct treatment and recovery services for serious mental illness or serious emotional disturbance

19% **Prevention & Early Intervention (PEI)**
Interventions prior to the onset of mental illness and early onset of psychotic disorders

5% **Innovation (INN)**
New approaches and community-driven best practices

Workforce Education and Training (WET)
Education, training and workforce development to increase capacity and diversity of the mental health workforce

Capital Facilities and Technology Needs (CFTN)
Buildings and technology used for the delivery of MHSA services to individuals and their families.

1% tax on personal income over $1 million
San Mateo County: $39.2M annual 5-year average through FY 21-22; ~15% of the BHRS Budget

MHSA Principles & Core Values

- Focus on wellness, recovery and resilience
- Cultural and linguistic responsiveness
- Consumer/client and family-driven services
- Integrated service experience
- Community collaboration

MHSA Planning Requirements

- Three-Year Plan & Annual Updates

What's in a 3-year Plan?

Existing Priorities

New Priorities

Expenditure Projections

What's in an Annual Update?

Program Specific Data and Outcomes

Implementation and Planning Updates

Changes to the 3-Year Plan

- Community Program Planning (CPP)
  - Diverse stakeholder Input
  - 30-Day Public Comment Period and Board of Supervisor approval

Community Program Planning Requirements

The process to be used by the County to develop Three-Year Program and Expenditure Plans and any updates, in partnership with stakeholders to:

1. Identify community issues related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the Mental Health Services Act

2. Analyze the mental health needs in the community

3. Identify and re-evaluate priorities and strategies to meet those mental health needs

Community Program Planning Framework

Nov 2022 – Dec 2023
- Review of local plans, assessments, evals/reports
- Community survey to prioritize needs

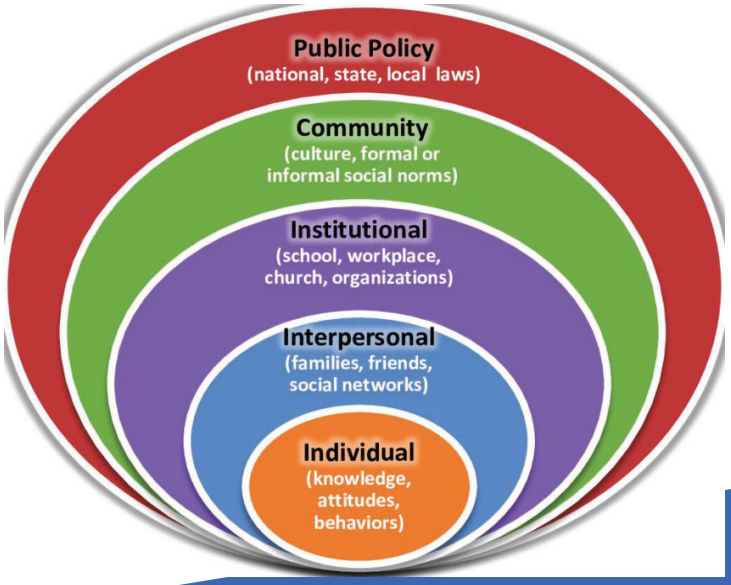
Jan – Mar 2023
- Community input sessions and key interviews
- Prioritization by MHSA Steering Committee

Apr – Jun 2023
- MHSARC 30-Day Public Comment
- Board of Supervisors Adoption

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Social Ecological Model

- Our health is impacted at various levels
- Social determinants of health
  - Access to healthcare
  - Education
  - Neighborhood
  - Built Environment
  - Economic Stability
  - Social and Community Context



SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Phase I: Needs Assessment

42 data sources reviewed:

- BHRS Data:
  - BHRS Cultural Competence Plan
  - BHRS Client Survey Data
  - MHSA Annual Updates
  - FSP Outcomes Report
  - BHC Crisis Coordination Recommendations
  - DHCS Performance Dashboard
  - Suicide Prevention Roadmap
  - Stigma Baseline Survey
  - Pride Center: COVID Impact Report
- Countywide Health Outcomes:
  - Dignity Community Health Needs Assessment (CHNA) Health and Quality of life
  - San Mateo County Health Alert Highlights Pandemics impact on Mental Health and Substance use
  - All Together Better Indicators SMC
  - California Health Interview Survey
- Older Adults
  - SMC Aging and Adult Services Area Plan
- Children and Youth
  - First 5 strategic plan
  - California Healthy Kids Survey 2019
  - Use of Acute Mental Health Care in U.S. Children's Hospitals Before and After Statewide COVID-19 School Closure Orders
  - 2022 California Children's Report Card
  - Supporting At-Risk Youth
- Other Special Populations
  - SMC Veterans Commission strategic plan
  - The Health, Mental Health, and Social Service Needs of Asian Americans and Pacific Islanders in California
  - Uncovering Unique Challenges: Variation in Unmet Mental Health Needs Among Latinx Ethnic Groups in California
  - Strategic Plan on Homelessness
  - Solutions for Supportive Homes

Preliminary Data findings

- MHSA Needs Assessment Summary
  1. Access to Care Continuum
  2. Adult/Older Adult Services
  3. Crisis Continuum
  4. Housing Continuum
  5. Workforce
  6. Youth Services

What are your thoughts about this data?

Does this data capture the needs well? Is anything missing?

Thank you for a great first meeting!

Next Meeting

December 5th, 2022

Homework:

1. Review needs assessment summary
    a. Needs Assessment summary review due November 18th

MHSA Three-Year Plan Workgroup

Meeting #2: December 15, 2022

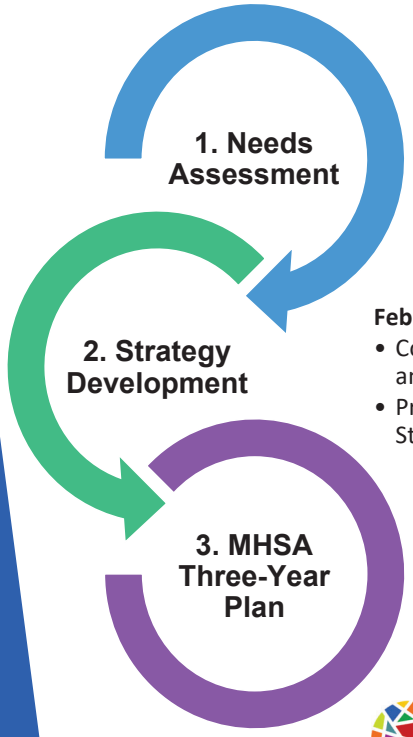
SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Welcome & Agenda

1. Introductions (5 min)
2. Workgroup Objectives & Role (15 min)
3. Phase I: Review Survey (40min)
4. Phase II: Strategy Development (20 min)

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Community Program Planning Framework



Nov 2022 – Jan 2023
- Review of local plans, assessments, evals/reports
- Community survey to identify challenges

Feb – May 2023
- Community input sessions and key interviews
- Prioritization by MHSA Steering Committee

June – July 2023
- MHSARC 30-Day Public Comment
- Board of Supervisors Adoption

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

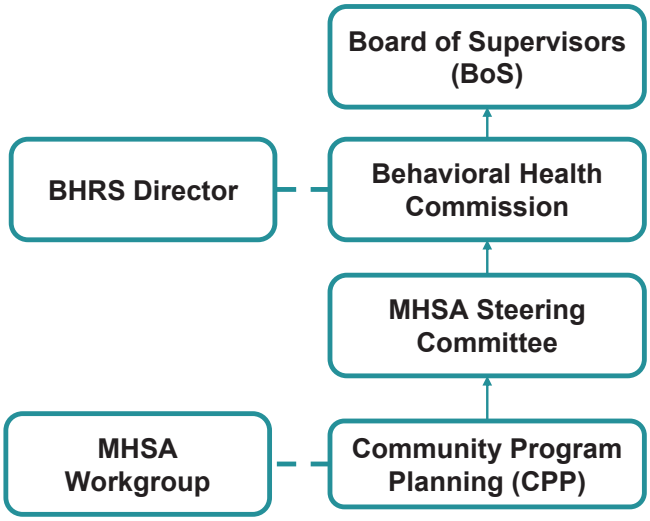
Workgroup Objectives

- Goal: Co-design and implement an MHSA 3- Year Plan Community Program Planning (CPP) process that is equitable, inclusive and honors and centers the voices of marginalized communities.

- Meeting #2 Objectives:
  1. Needs Assessment - finalize the community survey to identify behavioral health needs
  2. **Strategy Development - advise on the community input process and community engagement best practices, to ensure it is inclusive of all vulnerable communities**

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Local MHSA Decision-Making Structure



- *Guides and informs the CPP process*

- *Approves the 3-Year Plan*

- *Votes to Submit the 3-Year Plan, which includes the Areas of Focus and Strategies prioritized, for BoS Approval*

Community Input: 30-Day Public Comment Period & Public Hearing

- *Prioritizes the Areas of Focus and Strategies (e.g. programs, services, etc.)*

Community Input: Public Comment - Stories

- *Review Needs => Areas of Focus and Identifies Strategies (e.g. programs, services, etc.)*

Community Input: Survey + Input Sessions

Phase I: Survey Development

- Review and edit draft survey questions

Survey Distribution

How are you able to help us with the distribution of the survey to your network?

Who are the organizations or individuals you will you send the survey to?

Phase II: Strategy Development

What does “authentic community engagement” mean to you?

What could we do to support inclusive community input?

Input Sessions

- Input Sessions - Training Opportunity
    - 2 trainings (1 English, 1 Spanish)
- Excel sheet for stakeholders (possible homework)

Stakeholder Groups

Who is missing from the stakeholder list? Do you have a connection with this group?

Are there groups you are a part of that we could partner with to host a session?

Parking lot

- Current MHSA funded programs
- Assessment of resources allocated, gaps, best practices for *Areas of Focus*
- Limitation of MHSA (% allocations)

Thank you for a great meeting!

Next Meeting

January 12th, 2023

Homework:

1. Survey Distribution - live Dec 19th to Jan 20th
2. Stakeholder groups for Input Sessions (due Jan. 9)

MHSA Three-Year Plan Workgroup

Meeting #3: January 12, 2022

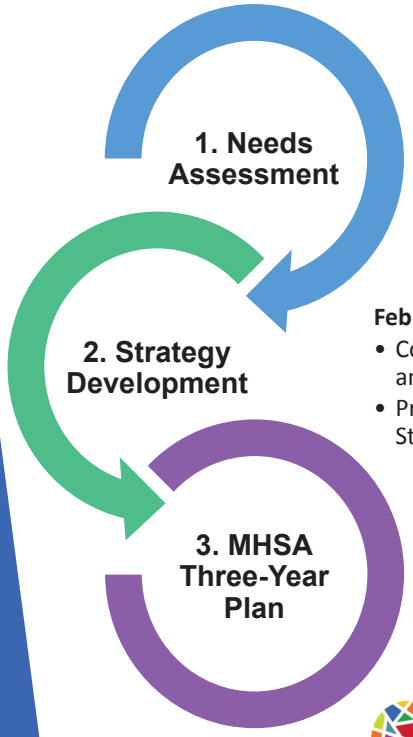
SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Welcome & Agenda

1. Introductions (5 min)
2. Workgroup Objectives (5 min)
3. Survey Reach (10 min)
4. Authentic Community Engagement (25 min)
5. Review Stakeholder List (15min)
6. Input Sessions (30 min)

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Community Program Planning Framework



Nov 2022 – Jan 2023
- Review of local plans, assessments, evals/reports
- Community survey to identify challenges

Feb – May 2023
- Community input sessions and key interviews
- Prioritization by MHSA Steering Committee

June – July 2023
- MHSARC 30-Day Public Comment
- Board of Supervisors Adoption

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Workgroup Objectives

- Goal: Co-design and implement an MHSA 3- Year Plan Community Program Planning (CPP) process that is equitable, inclusive and honors and centers the voices of marginalized communities.

- Meeting #3 Objectives:
  1. Strategy Development - advise on the community input process and community engagement best practices, to ensure it is inclusive of all vulnerable communities
  2. Input Sessions – support opportunities for all San Mateo County community members to provide input

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Phase I: Survey Reach

- Our survey has reached 37 people; our goal is 400+

Phase II: Strategy Development

What does “authentic community engagement” mean to you?

What could we do to support inclusive community input?

Phase II: Strategy Development

- Share stakeholder meeting scheduled
  - What are groups you are connected to, that represent stakeholders missing from our list?

Input Session Questions

1. Of the broad categories of needs identified, which would you like to focus our discussion on today?
   - Review categories
2. What are possible solutions (services, programs, infrastructure, etc.) to address the need?
   - Request Prevention, Workforce, and Direct Services strategies
3. If you had to select one strategy to focus on over the next 3 years, which would you prioritize?

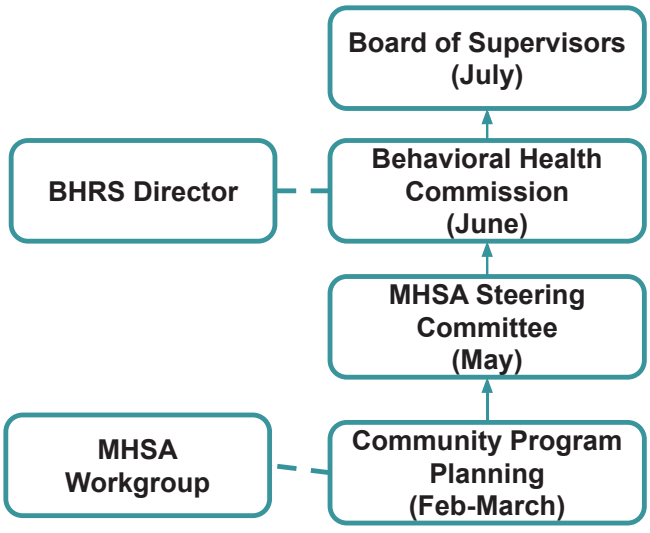
- Background & Reference Documents:
  - MHSA Info Sheet
  - MHSA Components and Programs
  - MHSA Budget
  - Needs Assessment Summary

Next Steps

- Gathering Public Comment Videos (April) - based on strategies prioritized during the input sessions
- MHSA Steering Committee Prioritization (May)
- BHC 30-Day Public Comment (June)

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Ongoing Engagement



- *Approves the 3-Year Plan*
- *Votes to Submit the 3-Year Plan, which includes the Areas of Focus and Strategies prioritized, for BoS Approval*
- *Prioritizes the Areas of Focus and Strategies (e.g. programs, services, etc.)*
- *Review Needs => Areas of Focus and Identifies Strategies (e.g. programs, services, etc.)*

Community Input: 30-Day Public Comment Period & Public Hearing

Community Input: Public Comment - Stories

Community Input: Survey + Input Sessions

- *Guides and informs the CPP process*

Parking lot

- Current MHSA funded programs - background info during input session
- Limitation of MHSA (% allocations) - background info during input session
- Assessment of resources allocated, gaps, best practices for *Areas of Focus* - planning process post 3-Year Plan

Stay Involved!

1. Optional Meeting to review Input Session data April 12th, 2-3pm
2. MHSA 3 Year Plan Facilitator Training
3. Input Sessions
4. Subscribe to MHSA listserv: www.smchealth.org/MHSA

Mental Health Service Act (MHSA) Three-Year Plan Facilitator Training

Join us if you are an advocate, community member, or part of an organization and would like to **facilitate a Community Input Session**

The MHSA Three-Year Plan identifies funding priorities to address mental health and substance use challenges in San Mateo County. We are facilitating Community Input Sessions starting in February 2023 and are looking for facilitators to help us gather input.

Facilitator Training Objectives:

- Learn about the MHSA Community Program Planning (CPP) process
- Receive tools to facilitate at least one Community Input Session
- Increase confidence in facilitation and data gathering for the MHSA Three-Year Plan

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

DATE & TIME

Wednesday January 25, 2023
3:00 pm – 4:30 pm (online)

How to Join?

Register for the Zoom training here:
https://us02web.zoom.us/meeting/register/tZEpduGsqTMjEtSibqZk70HwnLEtWGN-mYXy

Questions?

Contact: Tania Perez, MHSA 3 Year Plan Consultant, tsperezosu@g.ucla.edu

✓ Stipends are available for clients/family members
✓ Language interpretation* is provided if needed

To reserve language services, please contact us at least 2 weeks in advance.

The Mental Health Services Act (MHSA) provides a dedicated source of funding in California for mental health services by imposing a 1% tax on personal income over $1 million. To learn more, visit us at www.smchealth.org/MHSA.

MHSA Three-Year Plan Facilitator Training

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Welcome & Agenda

1. Introductions (10 min)
2. Objectives & Expectations (2 min)
3. MHSA Background (8 min)
4. MHSA Community Program Planning (CPP) Overview (10min)
5. Facilitation (60min)

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Workgroup Objectives

- Goal: Equip community members to confidently facilitate MHSA 3-Year Plan Input Sessions
- Meeting Objectives:
  1. Increase knowledge of the MHSA Community Program Planning (CPP) process
  2. Share tools for facilitation of input sessions
  3. Increase confidence in facilitation of input sessions, and data gathering

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Participation Expectations

- Active participation during the training including break out groups
- Commit to facilitate at least one input session
- Submit note template after each input session
- Be present, provide your input, stepping up and back
- Be brief and meaningful when voicing your opinion

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA Background

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

What is MHSA?

State Mental Health Hospitals Closed

California closed down hospitals that served folks with severe mental health challenges without adequate funding for community mental health supports

Impacts on community

Impacts were felt heavily among the community especially those who are most vulnerable

Community Organizing

Urgent need for recovery-based, accessible, community-based mental health services. Series of community organizing, partnership began to gain support for Proposition 63

Proposition 63 passed

Mental Health Services act, Proposition 63 is passed as a 1% tax on personal income over 1 million dollars

MHSA Components and Programs

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

About MHSA

76% **Community Services & Supports (CSS)**
Direct treatment and recovery services for serious mental illness or serious emotional disturbance

19% **Prevention & Early Intervention (PEI)**
Interventions prior to the onset of mental illness and early onset of psychotic disorders

5% **Innovation (INN)**
New approaches and community-driven best practices

Workforce Education and Training (WET)
Education, training and workforce development to increase capacity and diversity of the mental health workforce

Capital Facilities and Technology Needs (CFTN)
Buildings and technology used for the delivery of MHSA services to individuals and their families.

1% tax on personal income over $1 million
San Mateo County: $39.2M annual 5-year average through FY 21-22; ~15% of the BHRS Budget

MHSA Principles & Core Values

- Focus on wellness, recovery and resilience
- Cultural and linguistic responsiveness
- Consumer/client and family-driven services
- Integrated service experience
- Community collaboration

MHSA Planning Requirements

- Three-Year Plan & Annual Updates

What's in a 3-year Plan?

Existing Priorities

New Priorities

Expenditure Projections

What's in an Annual Update?

Program Specific Data and Outcomes

Implementation and Planning Updates

Changes to the 3-Year Plan

- Community Program Planning (CPP)
  - Diverse stakeholder Input
  - 30-Day Public Comment Period and Board of Supervisor approval

Community Program Planning (CPP) Requirements

The process to be used by the County to develop Three-Year Program and Expenditure Plans and any updates, in partnership with stakeholders to:

1. Identify community issues related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the Mental Health Services Act

2. Analyze the mental health needs in the community

3. Identify and re-evaluate priorities and strategies to meet those mental health needs

Community Program Planning Framework

Needs Assessment Areas

1. Access to Services
2. Behavioral Health Workforce
3. Crisis Continuum
4. Housing Continuum
5. Substance Use Challenges
6. Quality of Client Care
7. Youth Needs
8. Adult/Older Adult Needs

Needs Assessment Summary

Community Input Session Facilitation

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Facilitation training materials

- Tools that will be shared with you
  - CPP powerpoint (optional to use) + talking points
  - Facilitators manual
  - Note-taking template

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Cultural Humility Group Agreements

- LISTEN AS IF THE SPEAKER IS WISE; LISTEN TO UNDERSTAND
- PRACTICE "I" STATEMENTS WHEN SPEAKING
- OKAY TO RESPECTFULLY DISAGREE
- TAKE RISKS
- NO PRESSURE TO SPEAK
- BE DISCIPLINED ABOUT NOT MAKING ASSUMPTIONS
- NO BLAMING, NO SHAMING
- CONFIDENTIALITY IF STORIES ARE SHARED
- COURAGE TO INTERRUPT IF SOMETHING IS GOING AMISS OR BEING LEFT UNSAID: MAKE THE INVISIBLE VISIBLE
- VOICES, THOUGHTS, IDEAS, EXPERIENCES WELCOME
- PAY ATTENTION TO WHAT MOVES YOU: USE OOPS AND OUCH

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Setting the space

- Remember to create an inclusive space where folks feel heard
- As a facilitator you will do much more listening than speaking

MHSA Three-Year Plan Community Input Session

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What is MHSA?

State Mental Health Hospitals Closed

California closed down hospitals that served folks with severe mental health challenges without adequate funding for community mental health supports

Impacts on community

Impacts were felt heavily among the community especially those who are most vulnerable

Community Organizing

Urgent need for recovery-based, accessible, community-based mental health services. Series of community organizing, partnership began to gain support for Proposition 63

Proposition 63 passed

Mental Health Services act, Proposition 63 is passed as a 1% tax on personal income over 1 million dollars

MHSA Components and Programs

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About MHSA

76% **Community Services & Supports (CSS)**
Direct treatment and recovery services for serious mental illness or serious emotional disturbance

19% **Prevention & Early Intervention (PEI)**
Interventions prior to the onset of mental illness and early onset of psychotic disorders

5% **Innovation (INN)**
New approaches and community-driven best practices

Workforce Education and Training (WET)
Education, training and workforce development to increase capacity and diversity of the mental health workforce

Capital Facilities and Technology Needs (CFTN)
Buildings and technology used for the delivery of MHSA services to individuals and their families.

1% tax on personal income over $1 million
San Mateo County: $39.2M annual 5-year average through FY 21-22; ~15% of the BHRS Budget

MHSA Planning Requirements

- Three-Year Plan & Annual Updates

What's in a 3-year Plan?

Existing Priorities

New Priorities

Expenditure Projections

What's in an Annual Update?

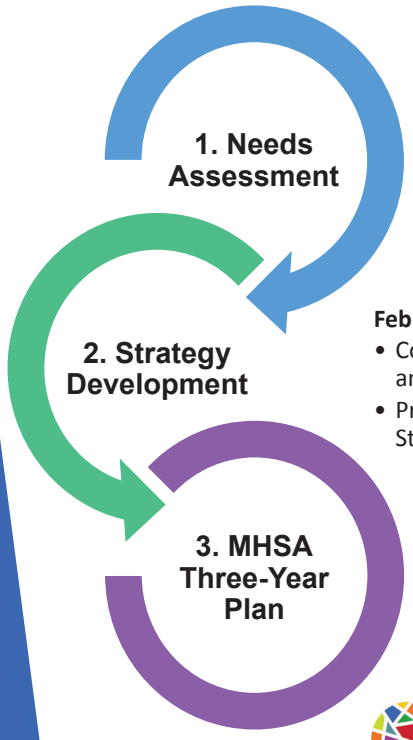
Program Specific Data and Outcomes

Implementation and Planning Updates

Changes to the 3-Year Plan

- Community Program Planning (CPP)
  - Diverse stakeholder Input
  - 30-Day Public Comment Period and Board of Supervisor approval

Community Program Planning Framework



Nov 2022 – Jan 2023
- Review of local plans, assessments, evals/reports
- Community survey to prioritize needs

Feb – May 2023
- Community input sessions and key interviews
- Prioritization by MHSA Steering Committee

June – July 2023
- BHC 30-Day Public Comment
- Board of Supervisors Adoption

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Community input questions

Regarding mental health and substance use services:

1. What are some of the challenges your community, family or you face?

2. What services/programs/resources could be effective in addressing those challenges? Provide Example

3. What considerations are needed for services/programs/resources, so that you and your family feel comfortable accessing them?

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Community input questions

4. What services/programs/resources are working well?

5. What type of services/programs/resources would you and your family like to see more of?

6. Of the strategies for addressing mental health and substance use, which one would you prioritize?

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Additional Resources & Data Collection

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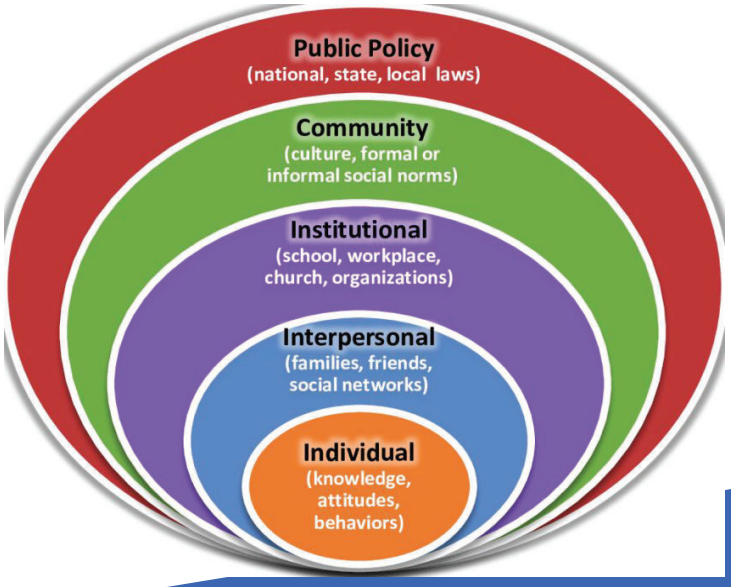
Social Ecological Model

- Our health is impacted at various levels
- Social determinants of health
  - Access to healthcare
  - Education
  - Neighborhood
  - Built Environment
  - Economic Stability
  - Social and Community Context
- Framework can be used as we probe and expand on points as a facilitator



Data collection

- Note taking template is available
  - Take notes of big picture ideas
  - Do not worry about capturing everything exactly how folks said it
  - Please return completed template to Tania Perez within 24 hours of the input session
  - Email back the template to the group that you visited

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Questions?

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Practice in small groups

- In groups of 3 you will decide on each of the following roles
  - Facilitator
  - Note taker
  - Community member
- You will practice for 5 minutes and then rotate to the next role
  - Each of you will experience all 3 roles
  - We will announce when time is up

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Debrief

- How was that experience for you?
- What are some things that folks in your group did well?
- What are some things to keep in mind?

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Next steps

- Keep up to date on the 3- Year plan at https://www.smchealth.org/bhrs/mhsa
- Email Tania Perez, tsperezosu@g.ucla.edu with any questions and notes
- Schedule sessions with groups you are a part of

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APPENDIX 3. MHSA THREE-YEAR PLAN COMMUNITY INPUT SESSIONS SUMMARY

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MHSA Three-Year Plan – Community Program Planning

Phase 2. Strategy Development

The MHSA Three-Year Plan is developed in collaboration with clients and families, community members, staff, community agencies and stakeholders. It includes priorities for future funding, program expansions and improvements, and expenditure allocations. The MHSA Three-Year planning process includes three phases, we are currently in Phase 2.

All of the challenges and concerns identified during the Needs Assessment phase were categorized into broad areas of need defined below.

As we move into the Strategy Development phase, there will be a number of **Community Input Sessions** facilitated throughout San Mateo County. During these sessions we will be asking participants to:

1. Decide which area of need to focus the discussion and brainstorming on.
2. Think about solutions to address the needs (programs, services, resources, etc.) that include prevention, workforce and direct service strategies.
    - *Prevention:* strategies that prevent individuals from developing a serious mental illness and substance use disorder through community supports and resources to reduce inequities and behavioral health stigma.
    - *Workforce:* strategies to recruit, increase the capacity of and retain diverse behavioral health staff across the behavioral health network of care including clinicians, contractors, peer workers and case managers.
    - *Direct Services:* strategies to engage, provide treatment and recovery supports for individuals living with serious mental health and substance use challenges.

Categorized Areas of Need

1. **Access to Services** - this category captures the needs of diverse cultures and identities such as race/ethnicity, LGBTQIA+, veteran status and age related to accessing mental health and substance use services, including community knowledge and education and culturally responsive approaches to engaging communities.

2. **Behavioral Health Workforce** - this category captures the needs related to recruiting, developing, supporting and maintaining a sufficient workforce to address the needs and the diversity of the community. This includes supporting individuals with lived experience as clients and/or family members of clients of mental health and substance

use services to join the workforce and support all services and programming.

3. **Crisis Continuum** - this category captures needs related to mental health and substance use crisis response, as well as appropriate community-based supports and stabilization during and after a crisis.

4. **Housing Continuum** - this category captures the housing needs for individuals living with mental health challenges ranging from assisted living facilities, to having access to permanent supportive housing, to early assessment of risk of homelessness and culturally responsive approaches and support with locating and maintaining housing.

5. **Substance Use** - this category captures the increasing need for substance use services and supports that are accessible, integrated and coordinated with mental health services.

6. **Quality of Care** - this category captures the needs of clients that are in treatment for mental health and/or substance use challenges to have timely access to care when needed, are successfully connected to services after an emergency and receive culturally responsive approaches to their treatment.

7. **Youth Needs** - this category captures mental health and substance use challenges for school to transition-age youth ages 6-25, it includes recent data for adolescent suicides, juvenile justice involvement, school-based and on-campus supports.

8. **Adult/Older Adult Needs** - this category captures mental health and substance use challenges for adults and older adults, it includes recent data related to increasing complexity of needs, general poor mental health outcomes, and suicide prevention needs.

MHSA Three-Year Plan Community Input Session

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Education, training and workforce development to increase capacity and diversity of the mental health workforce

Capital Facilities and Technology Needs (CFTN)
Buildings and technology used for the delivery of MHSA services to individuals and their families.

- Background & Reference Documents:
  - MHSA Info Sheet
  - MHSA Budget
  - MHSA Components and Programs

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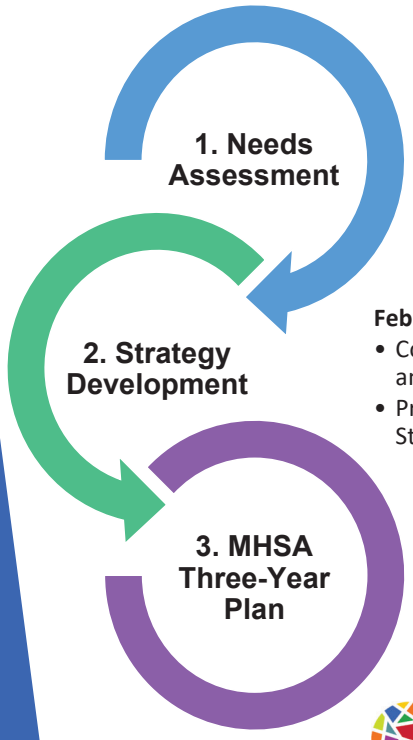

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Needs Assessment Categories

1. Behavioral Health Workforce
2. Access to Services
3. Housing Continuum
4. Crisis Continuum
5. Substance Use Challenges
6. Quality of Client Care
7. Youth Needs
8. Adult/Older Adult Needs

Reference: Needs Assessment Summary

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
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Categorized Areas of Need

1. Behavioral Health Workforce - this category captures the needs related to recruiting, developing, supporting and maintaining a sufficient workforce to address the needs and the diversity of the community. This includes supporting individuals with lived experience as clients and/or family members of clients of mental health and substance use services to join the workforce and support all services and programming.

- Needs Assessment Data:
  - Lack of sufficient staff led to negative impacts to clients and families
  - Hiring Spanish bilingual mental health clinicians and Transition Age Youth Family Partners is challenging
  - Not enough therapists to meet the high demand of incoming clients
  - High staff turnover led to staff doing whatever it takes to fill the need at the cost of burnout and impacting staff wellness
  - Need a more diverse workforce, BHRS clinicians need to share identities of clients for better care
- Community Response
  - Shortage of staff, due to inability to hire and pay staff at rates that allow them to live in the area
  - Peer partners and family partners are underutilized and temporary
  - Need life skills and mentoring
  - Increased need for diverse, bilingual, bicultural staff, however pay is the same as those without language capacity
  - More opportunities for furthering education, loan payback programs
  - Staff not able to work for county because of inflexible schedules, and benefits
  - Limited partnering/knowledge of supporting agencies/organizations
  - High turnover due to large caseloads leading to burn out
  - Need for increased county contract funding to increase local organizations capacity to recruit quantity and diversity of skilled staff
  - Foster relationships with community colleges or other academic institutions to create training programs
  - Inadequate training of public conservators, and public defenders
  - People require in person services

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Categorized Areas of Need

2. Access to Services-this category captures the needs of diverse cultures and identities such as race/ethnicity, LGBTQIA+, veteran status and age related to accessing mental health and substance use services, including community knowledge and education and culturally responsive approaches to engaging communities.

- Needs Assessment Data:
  - Race/ethnicity
    - Black/AA folks were less likely than other race/ethnicity to receive follow up MH services within 7 days and 30 days of an ED visit
    - Asian/Asian Americans have less access to mental health and substance use knowledge, behavior and beliefs to support stigma reduction
    - Reports of trauma exposure are extremely high among Latina migrant women, with prevalence rates of around 75%
  - LGBTQ+
    - LGBTQ population most affected by suicideal ideation in age group (24-44), and has a lack of access to services and understanding by providers
  - Children/youth and families
    - Referrals for mental health services through primary care increased 100% for youth
  - Social Determinants of Health
    - Low-income parents have higher frequency of depressive symptoms compared to middle and high income parents, continued impact of COVID-19 pandemic on families in areas of housing, financial, and food instabilities
  - Veterans
    - Need support with access, younger veterans include more women that would like more services targeted towards sexual assault
  - Older Adults
    - 35% of older adults identified an areas of concern as depressed mood

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Categorized Areas of Need

- Community Survey Data:
- Additional populations that experience challenges accessing mental health and substance use services
  - Folks with disabilities
  - Unhoused individuals
  - New immigrant families, refugees, asylum seekers, undocumented- newcomers
  - Farm Workers
  - Youth- Foster care, Incarcerated, African American, Native American
  - Families with young children
  - Monolingual community members
  - Incarcerated individuals and those who are reintegrating
  - Folks with private insurance
  - Low income families and individuals
  - Victims of domestic violence
  - Additional Race/ethnicities: Indian, White
- Age groups believed to have the greatest challenges accessing mental health and substance use services
  - Older Adults & Youth (16-25)
- Addressing **health insurance coverage** was believed to make the greatest impact in supporting mental health and substance use
- Challenges related to access include
  - Knowledge, awareness, stigma
  - Language barriers
  - Staff shortages
  - System navigation
  - Institutional barriers- long wait times, not enough flexibility, not enough beds in facilities

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Categorized Areas of Need

3. Housing Continuum - this category captures the housing needs for individuals living with mental health challenges ranging from assisted living facilities, to having access to permanent supportive housing, to early assessment of risk of homelessness and culturally responsive approaches and support with locating and maintaining housing.

- Needs Assessment Data:
  - Culturally Responsive Early Intervention Strategies
    - Black, Indigenous, People of Color are over-represented amongst unsheltered
    - Largest number of unsheltered folks are located in East Palo Alto and Redwood City
  - Navigation and Maintenance
    - Supporting families with housing, both maintenance and housing vouchers
  - Older Adults with Complex Needs
    - Very limited supply of licensed board and care providers willing to care for clients with complex health needs and limited financial resources, also continuing closure of B &C facilities
    - No intermediate care facility level of service in SMC
    - Limited resource of assistant living
    - Housing in a community setting with necessary supportive services for older adults has continually become an increasing challenge
  - Risk of homelessness
    - Housing crisis magnified for people living with mental illness
    - Aging parents struggle to find homes for their adult children with mental health challenges
    - Gap in permanent supportive homes
    - Correctional health services reported need for continued warm hand offs into temporary housing

Categorized Areas of Need

Community Survey Data:

- Lack of affordable housing, supportive housing rising housing costs in the county especially for low income, undocumented etc
- Complexity of paperwork for affordable housing is a barrier
- Services needed in addition to housing- case management, peer support, wrap around services
- Not enough board and care facilities, or transitional facilities for recovery
- Shelters feel unsafe and scarce
- Those with housing vouchers have a hard time relocating, vouchers pull folks out of treatment due to rules to qualify

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Categorized Areas of Need

4. Crisis Continuum- this category captures needs related to mental health and substance use crisis response, as well as appropriate community-based supports and stabilization during and after a crisis.

- Needs Assessment Data:
  - Stabilization and supports
    - Premature discharge from inpatient hospitalization (5150) while client is seriously impaired, leading to clients repeatedly getting 5150d
    - Need for mental urgent care facilities and stabilization units
  - Response
    - Police officers, behavioral health providers and community stakeholders face challenges in determining and implementing the proper ways to intervene during a behavioral health crisis
    - In 2016 a quarter of all fatal police shootings nationwide involved people with behavioral health or substance use conditions
    - Need for non-law enforcement mobile mental health crisis programs and emergency response
- Community Survey Data:
    - Need for more community education, knowledge, resources related to mental health emergencies
    - Institutional barriers- lack of follow up treatment after discharge, lack of beds in county, lack of coordination with other hospital systems
    - Social Determinants of Health- Language Barriers, Transportation
    - Criminalization of folks with mental health challenges by police
      - Police exacerbating trauma, should not be responding to mental health crisis, need more training, use of force result in fatalities

Categorized Areas of Need

5. Substance Use - this category captures the increasing need for substance use services and supports that are accessible, integrated and coordinated with mental health services.

- Needs Assessment Data:
  - Adults
    - Residential Treatment Programs encountered delayed admissions due to operating at half capacity
    - 430% increase in overdose related referrals to IMAT
    - Rates of drug overdose have been generally rising
    - Not enough treatment facilities in the county
  - Youth
    - Youth deaths due to drug overdose spiked during the pandemic
    - Whole Person Care reported a substantial increase in youth and young adults with increased cases of substance use and significant mental health issues
- Community Survey Data
  - Compound and complex trauma and co-occurring disorders pervasive in community
  - Limited staff, limited language capacity
  - Early education and addressing stigma is needed, prevention efforts
  - Lack of medical detox, some shelters don't accept folks without detox
  - Lack of harm reduction treatment
  - Lack of coordinated counseling, and transition services to AOD services and programs
  - Need crisis stabilization centers, recovery centers
  - More integration needed between substance use and mental health
  - Too few inpatient facilities
  - Need for substance use intervention in middle schools, county does not provide treatment to youth

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Categorized Areas of Need

6. Quality of Care - this category captures the needs of clients that are in treatment for mental health and/or substance use challenges to have timely access to care when needed, are successfully connected to services after an emergency and receive culturally responsive approaches to their treatment.

- Needs Assessment Data:
  - Timely Access for Acute Clients
    - Wait for treatment is prohibitive
    - Pandemic impacted client care and access to treatment
    - "Same Day Access" means a phone call to ACCESS line, same day call back for screening, 7 days for evaluation, and then a month before clients see a psychiatrist
  - Client Engagement in Treatment
    - 53% of clients attempting to access SUD services never received a first appointment
- Community Survey Data:
  - Lack of empathy from providers and trauma informed professionals
  - Lack of culturally appropriate services as barriers as well as language
  - Access to information, resources, for clients
  - Huge caseloads without caps, leads to waitlists, staffing shortages
  - Inadequate follow up, referrals, partnershing/knowledge of supporting agencies/organizations
  - Difficult to navigate services
  - Strengthen the continuum of care
  - Clients with psychosis are cut off from loved ones, during the span of 5150, this is dangerous
  - Inadequate usage of peer support
  - Need diverse providers

Categorized Areas of Need

7. Youth Needs - this category captures mental health and substance use challenges for school to transition-age youth ages 6-25, it includes recent data for adolescent suicides, juvenile justice involvement, school-based and on-campus supports.

- Needs Assessment Data:
  - Adolescent Suicides
    - Teens experienced higher serious psychological stress than adults
    - SMC high schoolers more likely to consider suicide than statewide
    - Youth with depression related feelings showed highest rate among NHPI followed by Latinx students
    - Self-inflicted injury highest among NHPI followed by Black students
  - Juvenile Justice Involvement
    - Redwood city highest rate for youth on probation and juvenile arrests
    - 70% of youth in juvenile justice system have a mental health disorder
  - School-Based supports
    - Wellness teams at sites overwhelmed, not all districts have wellness counselors.
- Community survey data:
  - Lack of providers available after school
  - Follow up is too spaced out where clients lose interest or fail to respond
  - Lack of parent education about mental health and substance use- LGBTQ+ population especially harmed
  - Need for mentoring and peer support
  - General mental health education for youth including services available to them delivered through schools
  - Lack of SUD RTC for youth, difficult to YTAC
  - Dedicated space and staff to provide services to incarcerated youth to increase use and privacy
  - Eating disorder support, and increased county infrastructure
  - High staff turnover affects students, and partner agencies have a medical/clinic based lens
  - Police officers in school sends wrong message to youth
  - Need to focus on foster care reform including more data, inclusion
  - Fentanyl danger and narcan availability in schools

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BEHAVIORAL HEALTH & RECOVERY SERVICES

Categorized Areas of Need

8. Adult/Older Adult Needs - this category captures mental health and substance use challenges for adults and older adults, it includes recent data related to increasing complexity of needs, general poor mental health outcomes, and suicide prevention needs.

- Needs Assessment Data:
  - Increased Complex Needs
    - Psychiatric Emergency Services events increased in 2020
    - COVID increased complexity of clients (comorbidities, co-occurring)
  - Poor Mental Health
    - Poor mental health days, south county and coast most affected
  - Suicide Prevention
    - Suicide deaths increased 32%
    - Increase for Asian population, White Males at disproportionate risk
- Community Survey Data:
  - High cost of living in the area
  - Need for community based classes that provide adults with mental health knowledge, about depression and services available
  - System navigation support is needed
  - Language barriers, transportation, technology as barriers to care
  - Affordable in-home supports and companionship care is needed
  - More robust in-field services provided to unsheltered individuals
  - Shortage of Board and Care facilities
  - Reduce stigma both societal and internal
  - Public spaces for explicit community building, as well as additional community programs
  - Isolation, grief, food insecurity
  - Resources for caregivers of elderly family members

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Input Session Questions

1. What are possible solutions (services, programs, infrastructure, etc.) to address the need?
   - Direct Service, Prevention and Workforce strategy
2. If you had to select one solution from each strategy to focus on over the next 3 years, which would you prioritize?

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Strategy Development – All Input Session Notes

Prioritized Needs	Stakeholder Groups

1. Access to Services
2. Youth Needs
3. Housing Continuum
4. Crisis Continuum
5. Substance Use Challenges
6. Quality of Client Care
7. Adult/Older Adult Needs
8. Behavioral Health Workforce
	• AOD Treatment Providers
	• Contractor Association
	• Housing Operations and Policy (HOP) Committee
	• Lived Experience Education Workgroup (LEEW)
	• Immigrant Parents/Families
	• Transition Age Youth (TAY)
	• Veterans
	• Coastside Collaborative
	• East Palo Alto Community Service Area (EPA CSA)
	• East Palo Alto Behavioral Health Advisory Group (EPABHAG)
	• North County Outreach Collaborative (NCOC)
	• Peer Recovery Organizations
	• Health Equity Initiatives (HEI)
	  ○ African American Community Initiative (AACI)
	  ○ Chinese Health Initiative (CHI)
	  ○ Filipino Mental Health Initiative (FMHI)
	  ○ Latino Collaborative (LC)
	  ○ Native and Indigenous People Initiative (NIPI)
	  ○ Pacific Islander Initiative (PII)
	  ○ PRIDE Initiative (PRIDE)
	  ○ Spirituality Initiative (SI)
	• BHC Older Adult Committee
	• BHC Child and Youth Committee
	• BHC Adult Committee
	• School Wellness Counselors

Prioritized Need	Strategies - Direct Service (black), Prevention (green)	Prioritized Strategy Ideas
Access to Services	**Chinese Health Initiative** • Increase of bilingual written resources for Chinese speakers • More multilingual access • Family approach to services in Chinese • Increase number of Chinese peers with lived experiences working in the BHRS system • 1 agency or regional clinic focused on providing culturally sensitive services to Chinese and Asian communities to coordinate county wide efforts to improve access • Increase outreach and communication about available services with faith-based organizations that serve the Chinese population • Educational trainings about mental health/substance use for Chinese speakers • Increase of communication, outreach and available services for Chinese communities	Coordinate behavioral health services for cultural and ethnic communities (centralize services, outreach and education for the Chinese community, hire bilingual/bicultural peer staff etc.).
	Steering Committee Break out Groups • Collect and utilize language capacity data to assess BHRS system • School-based programming for parents and students • Increase peer programs that are culturally relevant • Increase services on the coast for Asian American Community, by creating culturally relevant resources for treatment • Co-locating prevention services in key community organizations	Provide school-based behavioral health services starting in elementary and middle school; include early diagnosis and assessment at high school grade level
	BHC Retreat Notes • Priorities were across all needs categories and were organized into each of the needs	Conduct racial equity analysis of BHRS policies and procedures to identify barriers to accessing care; include service utilization and staff capacity data Expand the Health Ambassador Program to include diverse languages/cultures and subject expertise (substance use, justice involved, unhoused, human trafficking, etc)

Access to Services (cont'd)	**Coastside Collaborative** • Increase in direct grassroots outreach with food pantry services • Increase in outreach, warm hand offs, and communication so that community has more awareness of services available • Older adult program that addresses isolation and includes peer to peer facilitator support, social engagement and intergenerational work • Leverage library partnerships and social workers in the library program • Volunteer community programs that increase social engagement and community cohesion	Promote volunteerism to increase social engagement and community cohesion Expand services for older adults focused on addressing isolation, peer support, social engagement and intergenerational work
	EPA CSA • Increase mild to moderate partnerships with community based organizations to create a network of clinicians for referral • Improve outreach partnerships to include older adults, faith-based organizations and increased resources for promotora model outreach for Asian American, Filipinx, Latinx, Pacific Islander • Directory of organizations in EPA with insurance access information	Expand partnerships to include increased mild-to-moderate services and faith based organization engagement
Access to Services (cont'd)	**FMHI** • Increase drop in services that are open to the community that include wrap around services for youth • Increase in culturally responsive outreach for Filipinx community • Navigation supports that include visual access points • Increase availability of early diagnosis and assessment at high school	Expand drop in behavioral health services that includes wrap around services for youth
	Latino Collaborative • Provide phones/devices for clients • Create client centered services by meeting people where they are, in their language, with flexible hours • Prevention programs in other threshold languages • Mobile mental health services • Increase outreach to Latinx community • Increase access to school-based mental health services starting in elementary school and middle school	Co-locate prevention services (support groups, programs, workshops etc) in community settings such as faith based organizations, core-service agencies, community spaces, etc.)
Youth Needs	**BHC Youth Committee (Agencies/Providers)** • Crisis stabilization team • Peer supports for youth expanded • Non-law enforcement response teams	Address gaps in the crisis continuum for youth (increasing 5150 beds, language capacity, expand non-law enforcement

Youth Needs	• Crisis stabilization unit for youth and residential location in county with a dedicated team • School-based prevention program that is peer led • Disruption of school to prison pipeline	response, stabilization unit, crisis residential, etc.)
	BHC Youth Committee (Educators) • School-based wraparound services • Increase bilingual support groups with parents, peer mentors • School-based wellness centers expansion to every school • Increase access to social emotional learning curriculum • School based wellness centers • Affinity support groups • Navigation and education for caregivers	Expand school-based wellness centers
	BHC Youth Committee (Parents & Caregivers) • Safe space for youth to mingle with community outside of school • Resources for school educators/administration re: conflict resolution • Narcan availability in schools • Increased access to therapists • Drop in center or rehabilitation clinic • Communication with family members during 5150 situations in languages other than English • Increased beds available for youth who are 5150d • Prevention • Media campaign and key messaging to various communities • Prevention programming in all threshold languages • Improved intake and screening process • Harm reduction education • Supporting more alcohol and other drugs services in schools • Trauma mitigation for those exposed to mass shootings • Investment in warm line	Expand availability of diverse wellness counselors and clinicians on all school campuses Address gaps in the crisis continuum for youth (increasing 5150 beds, language capacity, expand non-law enforcement response, stabilization unit, crisis residential, etc.)

	School Counselors • School- based wellness center expansion using peer to peer model • Embed partner organizations within schools • Social emotional learning education	Expand school- based behavioral health education and services starting in middle school that includes family therapy and peer support groups for parents, youth and school staff Expand Social Emotional Learning (SEL) curriculum in schools
Youth Needs	**Pacific Islander Initiative** • Increase number of facilities where there is a higher need for services • Funding for wrap-around school-based services partnering with community organizations • Co-location of services in schools • Support parents in difficult conversations • Increase opportunities for programming outside school based afterschool with partner organizations	Expand after school based programming Integrate wrap around services in schools, in partnership with community-based organizations
	BHC Strategic Planning • Priorities were across all needs categories and were organized into each of the needs • Integrate behavioral health system into schools • Universal narcan availability in high school • Expand youth ambassador program • Increase services on crisis continuum between crisis and hospitalization	Provide Narcan in high schools (used to reverse opioid overdose).

Youth Needs	**Immigrant Parents and Families** • More frequent appointments • Crisis line so that there is no police intervention • Residential and rehabilitation substance use disorder programs • Decrease wait times to be seen by a therapist • Increase support groups for youth, and parents with mental health needs • Case management for health ambassadors and increased support • After school programming enrichment activities • School-based programming starting in middle school	Expand Health Ambassador Program for both Youth and Adults;include case management and increased support for ambassador's families
Youth Needs	**College students** • Resources accessible on college campuses and in school • Increase college mental health resources from 3 sessions to 6 • Family counseling in schools involving parents, child, professors and teachers • Older adult community mental health education focused on children and grandchildren • Using film/art to talk about generational trauma • School based initiatives: Increase school based wellness centers with peer to peer support groups	Expand school-based behavioral health education and services starting in middle school that includes family therapy and support groups for parents, youth and school staff
Housing Continuum	**BHC Adult Committee** • Housing conflict resolution support • Housing database • Supportive services for housing • Resource navigation with peers and streamlining case management • Outreach to Asian American population through media outlets • Automated benefits • Reduce housing application costs • PSA to destigmatize unhoused population • More access to integrated services for those that are co-occurring	Develop a comprehensive housing database that includes a real time waitlist and availability

	BHC Strategic Planning • Priorities were across all needs categories and were organized into each of the needs	Expand clinicians available to the Homeless Engagement Assessment Linkage team (field-based outreach, engagement and intervention services)
	Lived Experience Education Workgroup • Subleasing rooms/space of homeowners • Navigation services in the coastside • MHSA housing units based on different levels of need • Housing maintenance and supports to maintain housing, wrap around services, hoarding and substance use support • In-home supports for hoarding that includes support with cleaning • Resources to provide minor repairs for housing units • Address intergenerational trauma in recovery and treatment	Provide housing maintenance and peer support including case management, wrap-around services hoarding services, substance use supports, specialized services.
	PRIDE Initiative • BHRS control over more housing to lower HUD requirements in standard housing process • Meet other basic needs • Unisex non gendered bathrooms throughout county sites and clinics • Transitional housing/shelters for trans folks • Change rules/regulations for housing that impact employment • Support for parents with SMI children linkages to housing • Creation of database of housing programs • Increase housing programs for older adults • Case management expanded to all housing where folks with mental health challenges are living across housing spectrum • Outreach in shelters for unhoused people • Team that responds to folks staying in the home • Support for those who are released from jail to navigate housing • System navigation for undocumented clients • Expand communication on HIP housing or ADU's • Resources provided to community before eviction	Provide housing maintenance and peer support including case management, wrap-around services hoarding services, substance use supports, specialized services. Expand housing resources and supports specific for older adults
	MHSA Steering Committee	Expand housing slots for individuals living with behavioral health challenges

	• Create building where residents get housing vouchers to pay rent • Assist people with obtaining housing vouchers • Additional services on site at interim housing facilities • **Create housing with lower threshold of eligibility requirements**	that do not require homelessness as an eligibility requirement
Housing Continuum (cont'd)	**California Clubhouse** • Increase emergency shelter to 24/7 during weather events that affect unsheltered population • More case management for housing • Young adult housing program expansion to older adults • Pass policy regarding corporate unused space converted to housing • Create an ideal network of care for emergency services • Supportive housing with case managers and groups • Housing beyond studio apartment to house families • Streamline board and care application process • Housing database for people trying to obtain housing, that includes real time waitlist times and availability • Streamline B&C application process and reduce licensing cost • More funding towards section 8 housing or vouchers, including training on mental health • School-based supports on bullying and mental illness • Rent control • Increase emotional support in schools	Incentivize Board and Cares (streamline application process, reduce/subsidize licensing costs) Provide supports for section 8 housing including funding, vouchers, and training to landlords
Housing Continuum (cont'd)	**Housing Operations Committee** • More supportive housing of various forms w/various levels of supports • Expansion of board and care • Shared vouchers to increase housing • Trauma informed care, increase case managers and specialized therapy for those who hoard • Programs for unhoused clients to receive support on keeping their home clean to retain housing as well as educational supports • Expand slots for housing locator and access specialized services • Skills based learning with onsite support • Increase number of tenants' rights workshops	Provide housing navigation and locator resources; include re-entry supports, bilingual peer supports, streamlined case management, simplified housing application and subsidized fees

Housing Continuum (cont'd)	**Solutions for Supportive Homes** • Integration of services to support dual diagnosis • Increase of therapists to FSP Clients • Assistance with resource navigations and forms • Increase face to face care • More housing to fit range of needs, differing types of supports • Fill gap between board and care and MHSA housing • Best practices for parents who are no longer able to provide care • End short term appointments of staff • Create a feedback mechanism that centers family and quality of care • More supports before hospitalization is required • Expansion of crisis services by non-law enforcement • Reduce housing barriers due to justice involvement • Case workers and housing for older adults	Incentivize board and cares (streamline application process, reduce/subsidize licensing costs, etc) Expand housing resources and supports specific to older adults
Crisis Continuum	BHRS Youth Leadership • Create a stabilization center in the County used as a step-down from hospitalization • Increase intensive outpatient services via day treatment program, and detox center • Create facility to support youth while they are in withdrawal and stabilizing	Create stabilization units and dedicated teams Create a youth crisis residential in the county Expand step down from hospitalization facilities, programs and teams
	MHSA Steering Committee • Increase detox supports • Increase availability of narcan in community centers and high schools • Increase short-term respite care opportunities • Increase time in programs 90 days instead of 30 • LGBTQ+ sensitive and culturally responsive emergency unit • Increase of re-entry programs for youth under age 18 coming from hospitalization or incarceration • Community based crisis stabilization centers	Expand intensive outpatient services (extended Intensive Outpatient Programs for youth, day treatment programs, detox centers, etc.) Provide respite care and language appropriate navigation supports for parents with children who experience a behavioral health crisis (5150, psychiatric emergency services, hospitalization, etc.)

	• Non-armed stand alone 24/7 mobile mental health crisis response unit designed to independently serve the entire community • Increase number of drop in centers for clients with dual diagnosis • Respite and navigation supports for parents with children who are discharged from PES with peer/family support workers	Expand non-armed 24/7 mobile mental health crisis response to serve the entire community Expand drop in centers for individuals that struggle with mental health and/or substance use
Substance Use Challenges	**BHC AOD Committee** • Outreach to different cultural groups culturally tailored interventions connected to geography • Increase access to Narcan for both consumers and their family members • Integrated care: Dual diagnosis and treatment with peer support • Longer term sober living arrangements • Address gap between prevention and early intervention resources	Create integrated services for complex needs including individuals with dual diagnosis or co occurring Provide access to Narcan for clients and family members Create longer term sober living arrangements Expand early intervention resources for addiction
	Voices of Recovery San Mateo County • Streamline access to get into treatment and address long waitlists • More shelters in remote areas • More outreach to those that are unsheltered and impacted by SUD • Expansion of harm reduction by expanding housing vouchers • Address Social Determinants of Health and basic needs with permanent housing • Drop-in center with linkages to recovery resources • Family centered recovery support that includes child care at every stage • Support beyond medication • Support for dual diagnosed people designed for specific types of care • After School program where children learn about SUD • Groups and support to kids that are peer focused • Drop in center where kids can express themselves • Culturally relevant outreach about substance use (2) • More resources for family reunification including emotional support for parents and education about parenting	Expand non-medication supports for individuals with addiction Expand recovery focused drop-in centers Expand resources for reunification (support for parents, how to talk/interact with children, etc.) Provide family-centered recovery supports that includes child care at every stage Address intergenerational trauma in recovery and treatment

	• More outreach for SUD	Provide education about substance use prevention starting in elementary school (how to say no, healthy boundaries, etc)
Quality of Client Care	**African American Community Initiative** • Shorten wait time it takes to receive a new therapist • Create a process for triage between access call center and an appt • Ongoing communication and peer support for resource navigation in crisis situations • Best practice sharing across county clinics • Intake process needs to be streamlined • Peer programs for system navigation and support • Use Lived Experience Academy graduates in education and outreach opportunities • Train faith based organizations on mental health	Provide ongoing resource navigation and peer support in crisis situations Create client centered services (meet people where they are, provide virtual/in-person, services in their language, flexible hours, etc,) Develop a streamlined BHRS intake process across the network of care
	Native Indigenous Pacific Islander • Best practices need to be shared across clinics • Integrated supports across clinics through identification of supports that can be offered across the county • Additional partnerships needed for referral to substance use supports for clients with ACE insurance • Partner with first 5 and link to mental health resources • Reclaim roots to allow healing • Partner mental health resources with indigenous community spaces, event sponsorship and cultural healers • Start interventions very young by addressing ACE, SDOH, and intergenerational trauma with holistic practices	Develop partnerships for substance use referrals for clients with Access and Care for Everyone (ACE) Develop partnerships with indigenous community spaces and cultural healers Address Adverse Childhood Experiences, Social Determinants of Health and intergenerational trauma
Adult/Older Adult Needs	**BHC Older Adult Committee** • Respite care for clients • Support for clients in assisted living and respite away from facility • Housing accessible to homebound clients • Expanding oasis capacity to serve greater older adult population • NMT map to hoarding	Create internal processes to regularly review utilization and outcome data to inform responsive services for older adults.

	• Hoarding support and linkage to services • More capacity for neuro psych testing • Create internal processes to access quality of services • Mild to moderate groups for specific therapy modalities • Caregiver support group • Housing supports: Assessment of cognitive abilities and ability to care for selves • Client brochure with information about cognitive decline, evaluation resources • Stronger linkages between BHRS programs and community based programs • Increase communication strategy in multiple languages, including SMC Alert integrated in cities • Hoarding prevention • Outreach for mental health and wellness and resources available • Culturally relevant suicide prevention		Expand capacity for neuropsychological evaluation and diagnosis. Expand in-home hoarding supports (linkages to services, case management, specialized therapy, decluttering, etc.) Expand the OASIS team peer specialist' support for older adults, caregivers and family members. Develop an outreach and communication strategy on behavioral health and wellness in multiple languages; leverage existing networks (SMC Alert, neighborhood CERTs, etc.). Expand culturally relevant suicide prevention strategies.
	Spirituality Initiative • Peer certification process • Housing maintenance and peer supports • Partner with organizations that can support individuals with complex needs • Partner with organizations that can provider prevention services prior to complications		Expand services for individuals with complex needs; develop partnerships with organizations that can support complex client needs. Expand prevention services to older adults prior to complications; develop partnerships with organizations that can provide these services.
Behavioral Health Workforce	Pipeline/Recruitment • Pipeline program that partners with local community colleges, to increase Black therapists • Recruitment of more BIPOC therapists • Peer workers and case managers to aid in housing navigation	Retention • Continue the BHRS lump sum for retention bonuses for contracted providers • Retention bonuses to compete with the rising cost of the Bay Area	Training • Training that is centered on staff wellness, staff mental health services, and provides incentives as well as resources • Establish an incubator of training development for BIPOC students

	• Outreach to high schools, Black student Unions, College campuses in order to create a pipeline program for Black Students that would like to become mental health providers • Increase number of family partners that aid in resource navigation, and are bilingual • Increase hiring of diverse counselors in schools by creating more entry level positions and internships for BIPOC students • School wellness counselors and clinicians on campus at all schools • Increased hiring of peer specialists, trained peers to deliver support for older adults, caregivers of older adults and family members, expanding the OASIS team • Increase diversity of mental health/substance use staff by creating a pipeline program for Asian American and African American staff • Increase hiring of bilingual staff that are culturally similar to the population that is served	• Expansion and recognition of outreach workers, peer support workers, community health educators by increasing wages, giving them titles and a voice in administration decision-making • Loan repayment program for outreach workers/peer support workers to return to school • Remove temporary positions and create permanent roles especially those that interface with community partners (2) • Invest in peer support workers including training, fair compensation, career paths, and flexible hours (5) • Increase number of school counselors, wellness counselors and implement recommended caseload of 1:250 • Create a program for peer on peer support for school counselors	with lived experience pursuing the mental health field • Incentives for landlords for learning about mental health and offering units for those who are suffering from mental health challenges • Training about integrate holistic care providers such as curanderas, chinese medicine doctors who are culturally attuned to community needs • Scholarships for trainings so that support staff can enter mental health care field • Train teachers and administrators on how to support, and recognize symptoms of mental health in students and refer them to resources(2) • Increase collaboration between the county and the VA by creating coalitions • Train firefighters and EMTs about on mental health • Train teachers and school administrators on how to support students after hospitalization including IEP supports • Increase collaboration and partnership of underrepresented groups for strategic partnerships

			• Training on linguistic and clinical modalities related to culture
Prioritized Strategies	Create a pipeline program focused on increasing Asian American and African American behavioral health staff, include partnerships with high schools, student unions and local community colleges. . Target recruitment activities to reach black, indigenous, people of color (BIPOC) communities (e.g., partner with BIPOC-focused communities and student organizations and networks) Create more entry level positions and internships for students of diverse backgrounds. Continue retention bonuses for contracted service providers. Invest in retention of outreach workers, peer support workers, and community health educators (training, fair compensation, career paths, and flexible hours, engage in decision-making). Implement incentive programs (loan repayment, stipends/scholarships, part time and flexible work schedules, etc.) for outreach workers/peer support workers to return to school. Remove temporary positions and create permanent roles especially for those that interface with community partners. Support school wellness counselor retention (implement recommended caseload of 1:250, create peer on peer support program, etc.).		
Other Priority Areas			
Priority Populations: Veterans	Key Stakeholders • Provide military cultural lens and let folks know the VA is available • Instruments and tools to identify if someone has served in the military • Integrate MH into primary care • Mobile apps to track daily mental health feelings • Suicide prevention • Create partnership between county and VA • Create resources for women veterans and sexual assault		Create partnership between the County and Veterans Administration to increase supports for veterans (integration with primary care services, resources for women veterans on sexual assault, suicide prevention for veterans, etc).

Priority Population: Transition Age Youth	Canyon Oaks TAY (Key Stakeholder Interviews): ● More consistent therapists in school-based services ● Increase in-person services ● Family therapy, couples therapy for parents that addresses culture (latinx) +2 ● More support around IEP's ● More support after hospitalization ● More field trips with COYC and school ● Increase school counselors ● Education about benefits and dangers of social media and mental health class +2 ● Education that centers body image classes and someone to talk to ● More activities for youth to engage in after school ● Education for parents about mental health ● Outside activities with parents ● Start school-based mental health services in middle school	Expand school-based behavioral health education and services starting in middle school that includes family therapy and support groups for parents, youth and school staff

APPENDIX 4. MHSA THREE-YEAR PLAN STRATEGY RECOMMENDATIONS & PRIORITIZATION

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA Three-Year Plan Strategy Recommendations

FY 23-24 to FY 25-26

30+ community input sessions and key interviews were conducted to brainstorm strategies to address San Mateo County behavioral health needs. The MHSA Steering Committee will be voting to prioritize across the Identified Needs and across the Strategy Recommendations. This prioritization will inform the allocation of resources over the next three-years. Across all community input sessions, three core themes emerged. These components will be incorporated into EVERY prioritized strategy:

1. **Increase community awareness** and education about behavioral health topics, resources and services
2. **Embed peer and family supports** into all behavioral health services
3. **Implement culturally responsive** approaches to address existing inequities that are data-driven

Direct Services & Supports / Prevention Early Intervention

Identified Needs	Strategy Recommendations
Access to Services	1. Coordinate behavioral health services for cultural and ethnic communities (centralize services, outreach and education for the Chinese community, hire bilingual/bicultural peer staff, etc.).
	2. Expand drop-in behavioral health services that includes access to wrap around services for youth.
	3. Provide school-based behavioral health services starting in elementary and middle school; include early diagnosis and assessment at high school grade level.
	4. Co-locate prevention services (support groups, programs, workshops, etc.) in community settings such as faith-based organizations, core-service agencies, community spaces, etc.
	5. Conduct racial equity analysis of BHRS policies and procedures to identify barriers to accessing care; include service utilization and staff capacity data.
	6. Expand services for older adults focused on addressing isolation, peer support, social engagement and intergenerational work.
	7. Expand the Health Ambassador Program to include diverse languages/cultures and subject expertise (substance use, justice involved, unhoused, human trafficking, etc.)
	8. Expand outreach partnerships to include increased mild-to-moderate services, faith-based organizations and veteran engagement.
	9. Promote volunteerism to increase social engagement and community cohesion.

Recruitment & Retention Strategies

Identified Need	Strategy Recommendations
Behavioral Health Workforce	1. Create a pipeline program focused on increasing Asian American and African American behavioral health staff, develop partnerships with local and neighboring academic and non-academic programs.
	2. Create more entry level positions and internships for students of diverse backgrounds; streamline hiring processes (e.g., onboarding and process to hire interns).
	3. Target recruitment activities to reach black, indigenous, people of color (BIPOC) communities (e.g., partner with BIPOC-focused communities and student organizations and networks).
	4. Implement recruitment and retention financial incentives such as retention bonuses, signing bonuses, educational loan repayment for staff and contracted providers.
	5. Examine and adjust caseload size and balance, particularly for bilingual staff.
	6. Expand type, flexibility, and access to staff wellness and engagement opportunities (e.g., appreciation, healing activities, mentoring, behavioral health supports, networking events).
	7. Explore opportunities for alternative and flexible schedules and remote work.
	8. Implement supports for direct service staff, including peers, to advance in their careers, specifically BIPOC staff (e.g., scholarships to pursue licensure/credentials, mentorship).
	9. Invest in support, retention and leadership development of peer and family support workers (training, fair compensation, career ladders, flexible hours, and mentorship).
	10. Address extra help and contracted positions, especially for those that interface with the community.
	11. Research, plan, and implement compensation and benefits that are aligned with competing agencies and neighboring counties (e.g., salaries, cost of living, retirement plans, housing vouchers).

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Crisis Continuum	1. Create stabilization unit(s) and dedicated teams.
	2. Expand step-down from hospitalization facilities, programs and teams (e.g., respite centers).
	3. Create a youth crisis residential in the County.
	4. Expand intensive outpatient services (extended Intensive Outpatient Programs for youth, day treatment programs, detox centers, etc.).
	5. Provide respite care and language-appropriate navigation supports for parents with children who experience a behavioral health crisis (5150, psychiatric emergency services, hospitalization, etc.).
	6. Expand non-armed 24/7 mobile mental health crisis response to serve the entire community.
	7. Expand drop-in centers for individuals that struggle with mental health and/or substance use.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Housing Continuum	1. Expand clinicians available to the Homeless Engagement Assessment Linkage team (a field-based outreach, engagement and intervention services).
	2. Expand supportive housing slots for individuals living with mental health and substance use challenges that do not require homelessness as an eligibility requirement.
	3. Provide housing maintenance and peer supports including case management, wrap around services, hoarding resources, and specialized services for older adults and other vulnerable communities.
	4. Develop a comprehensive housing database that includes real time waitlist times and availability.
	5. Incentivize board and cares (streamline the application process, reduce/subsidize licensing costs, etc.).
	6. Provide housing navigation and locator resources; include re-entry supports, bilingual peer supports, streamlined case management, simplified housing application and subsidized fees.
	7. Provide supports for section 8 housing including funding, vouchers, and training to landlords.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Substance Use Challenges	1. Create integrated services for complex needs including individuals with dual diagnosis or co-occurring mental health and substance use needs.
	2. Create longer-term sober living arrangements.
	3. Expand non-medication supports for individuals with addiction.
	4. Expand recovery-focused drop-in centers.
	5. Expand resources for reunification (support for parents, how to talk/interact with their children, etc.).
	6. Provide access to Narcan for clients and family members.
	7. Provide family-centered recovery supports that includes child care at every stage.
	8. Address intergenerational trauma in recovery and treatment.
	9. Expand early intervention resources for addiction.
	10. Provide education about substance use prevention starting in elementary school (how to say no, healthy boundaries, etc.).

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Quality of Client Care	1. Provide ongoing resource navigation and peer support in crisis situations.
	2. Create client centered services (meet people where they are, provide virtual/in-person, services in their language, flexible hours, etc.).
	3. Implement best practice sharing across BHRS clinics, including integrated services and identification of supports that can be offered across the county.
	4. Develop a streamlined BHRS intake process across the network of care.
	5. Develop partnerships for substance use referrals for clients with Access and Care for Everyone (ACE).
	6. Develop partnerships with indigenous community spaces and cultural healers.
	7. Address Adverse Childhood Experiences, Social Determinants of Health, and intergenerational trauma.

Direct Services & Supports / Prevention Early Intervention

Identified Need	Strategy Recommendations
Adult/Older Adult Needs	1. Create internal processes to regularly review utilization and outcome data to inform responsive services for older adults.
	2. Create partnership between the County and Veterans Administration to increase supports for veterans (integration with primary care services, resources for women veterans on sexual assault, suicide prevention for veterans, etc).
	3. Expand capacity for neuropsychological evaluation and diagnosis.
	4. Expand in-home hoarding supports (linkages to services, case management, specialized therapy, decluttering, etc.)
	5. Expand services for individuals with complex needs; develop partnerships with organizations that can support complex client needs.
	6. Expand the OASIS team peer specialist' support for older adults, caregivers and family members.
	7. Develop an outreach and communication strategy on behavioral health and wellness in multiple languages; leverage existing networks (SMC Alert, neighborhood CERTs, etc.).
	8. Expand culturally relevant suicide prevention strategies.
	9. Expand prevention services to older adults prior to complications; develop partnerships with organizations that can provide these services.

Direct Services & Supports / Prevention Early Intervention

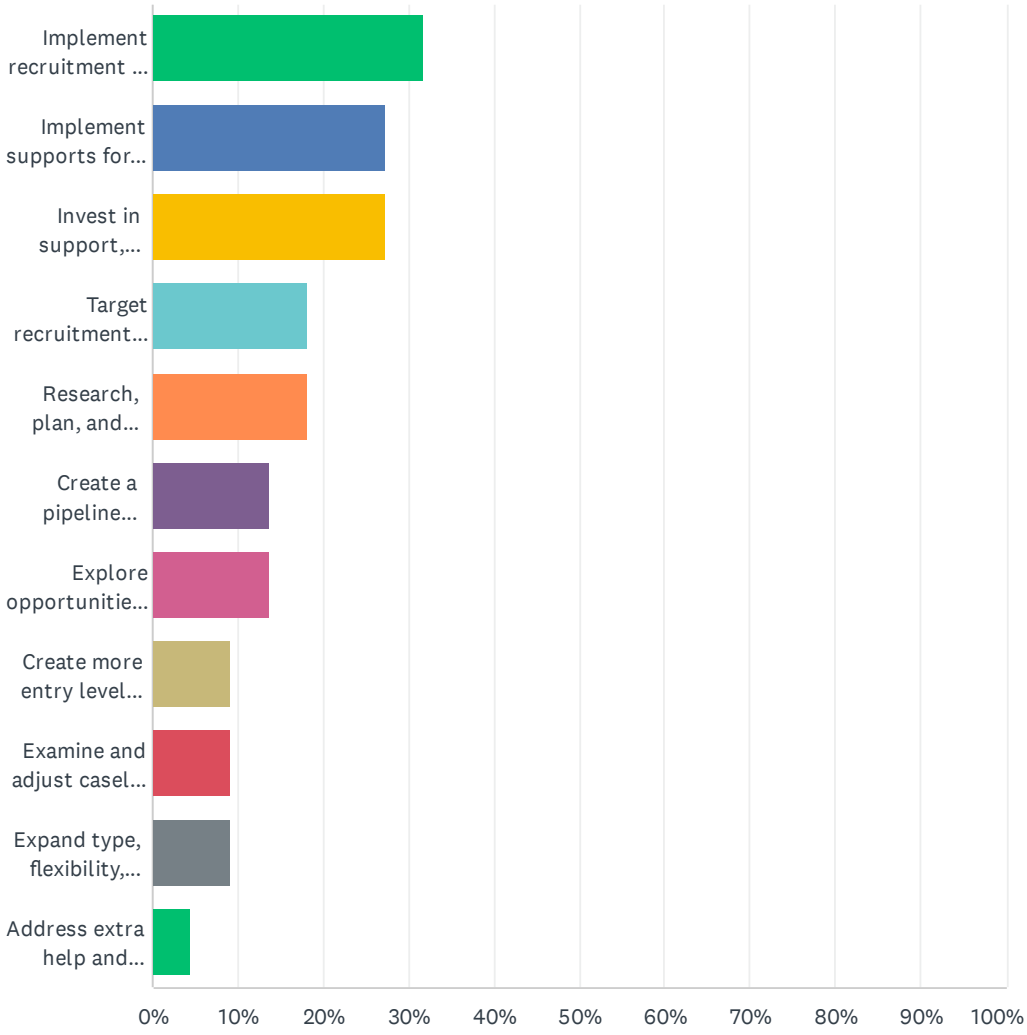
Identified Need	Strategy Recommendations
Youth Needs	1. Address gaps in the crisis continuum for youth (increase 5150 beds, language capacity, expand non-law enforcement response, stabilization unit, crisis residential, etc.).
	2. Expand school-based behavioral health education and services starting in middle school that includes family therapy and peer support groups for parents, youth, and school staff.
	3. Expand school-based wellness centers.
	4. Expand afterschool-based programming.
	5. Expand availability of diverse wellness counselors and clinicians on all school campuses.
	6. Integrate wraparound services in schools, in partnership with community-based organizations.
	7. Provide Narcan in high schools (used to reverse opioid overdose).
	8. Expand Social Emotional Learning (SEL) curriculum in schools.
	9. Expand the Health Ambassador Program for both Youth and Adults; include case management and increased support for ambassador's families.

Q1 Please provide your name. This will help us follow up with MHSA Steering Committee members we don't hear from by the deadline (May 16th).

Answered: 22 Skipped: 0

Q2 BEHAVIORAL HEALTH WORKFORCE: Which of the following recommended strategies would you prioritize for BHRS to implement over the next three years? Please select your top 3.

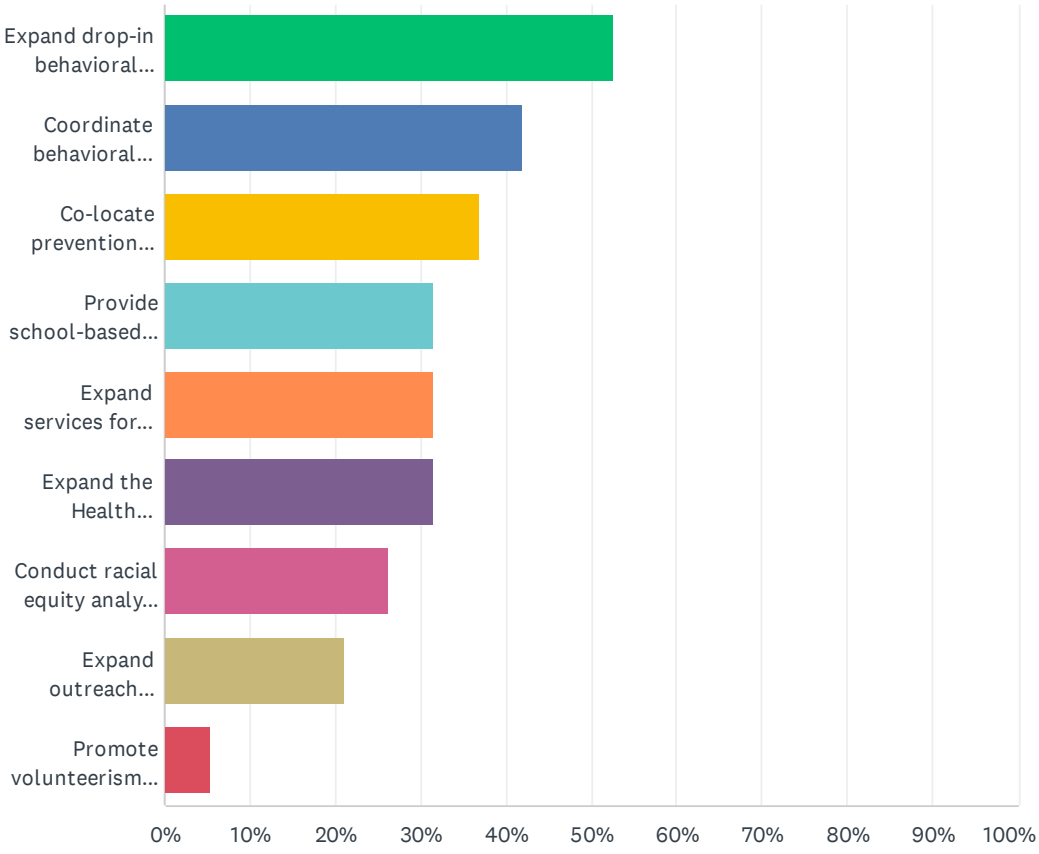
Answered: 22 Skipped: 1



ANSWER CHOICES	RESPONSES	
Implement recruitment and retention financial incentives such as retention bonuses, signing bonuses, educational loan repayment for staff and contracted providers.	31.82%	7
Implement supports for direct service staff, including peers, to advance in their careers, specifically BIPOC staff (e.g., scholarships to pursue licensure/credentials, mentorship).	27.27%	6
Invest in support, retention and leadership development of peer and family support workers (training, fair compensation, career ladders, flexible hours, and mentorship).	27.27%	6
Target recruitment activities to reach black, indigenous, people of color (BIPOC) communities (e.g., partner with BIPOC-focused communities and student organizations and networks).	18.18%	4
Research, plan, and implement compensation and benefits that are aligned with competing agencies and neighboring counties (e.g., salaries, cost of living, retirement plans, housing vouchers).	18.18%	4
Create a pipeline program focused on increasing Asian American and African American behavioral health staff, develop partnerships with local and neighboring academic and non-academic programs.	13.64%	3
Explore opportunities for alternative and flexible schedules and remote work.	13.64%	3
Create more entry level positions and internships for students of diverse backgrounds; streamline hiring processes (e.g., onboarding and process to hire interns).	9.09%	2
Examine and adjust caseload size and balance, particularly for bilingual staff.	9.09%	2
Expand type, flexibility, and access to staff wellness and engagement opportunities (e.g., appreciation, healing activities, mentoring, behavioral health supports, networking events).	9.09%	2
Address extra help and contracted positions, especially for those that interface with the community.	4.55%	1
Total Respondents: 22		

Q3 ACCESS TO SERVICES: Which of the following recommended strategies would you prioritize for BHRS to implement over the next three years? Please select your top 3.

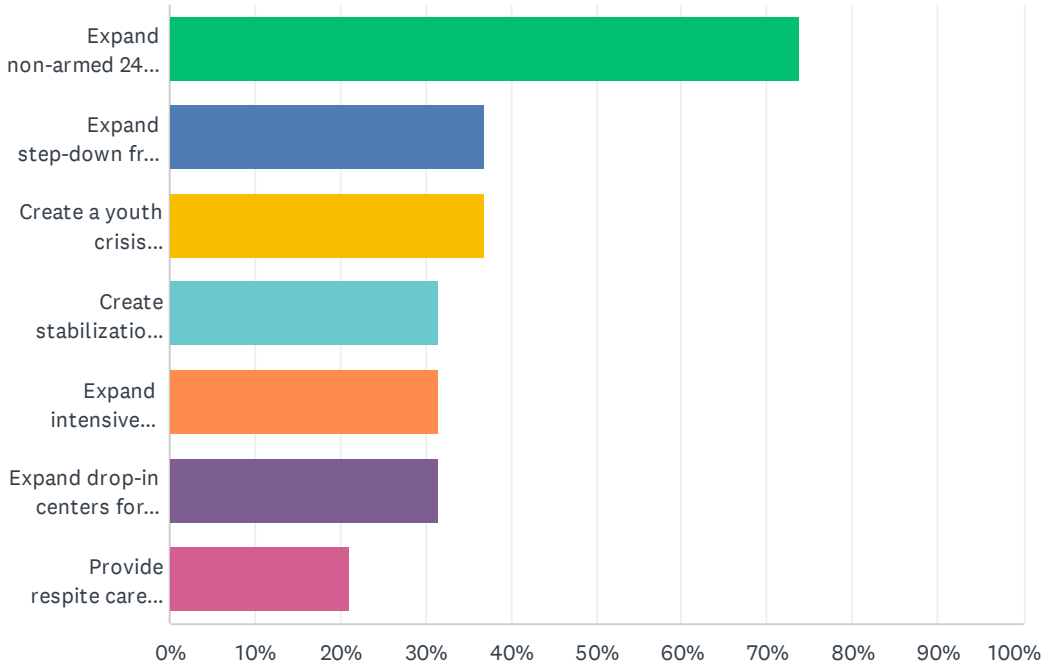
Answered: 19 Skipped: 4



ANSWER CHOICES	RESPONSES	
Expand drop-in behavioral health services that includes access to wrap around services for youth.	52.63%	10
Coordinate behavioral health services for cultural and ethnic communities (centralize services, outreach and education for the Chinese community, hire bilingual/bicultural peer staff, etc.).	42.11%	8
Co-locate prevention services (support groups, programs, workshops, etc.) in community settings such as faith-based organizations, core-service agencies, community spaces, etc.	36.84%	7
Provide school-based behavioral health services starting in elementary and middle school; include early diagnosis and assessment at high school grade level.	31.58%	6
Expand services for older adults focused on addressing isolation, peer support, social engagement and intergenerational work.	31.58%	6
Expand the Health Ambassador Program to include diverse languages/cultures and subject expertise (substance use, justice involved, unhoused, human trafficking, etc.)	31.58%	6
Conduct racial equity analysis of BHRS policies and procedures to identify barriers to accessing care; include service utilization and staff capacity data.	26.32%	5
Expand outreach partnerships to include increased mild-to-moderate services, faith-based organizations and veteran engagement.	21.05%	4
Promote volunteerism to increase social engagement and community cohesion.	5.26%	1
Total Respondents: 19		

Q4 CRISIS CONTINUUM: Which of the following recommended strategies would you prioritize for BHRS to implement over the next three years? Please select your top 3.

Answered: 19 Skipped: 4



ANSWER CHOICES	RESPONSES	
Expand non-armed 24/7 mobile mental health crisis response to serve the entire community.	73.68%	14
Expand step-down from hospitalization facilities, programs and teams (e.g., respite centers).	36.84%	7
Create a youth crisis residential in the County.	36.84%	7
Create stabilization unit(s) and dedicated teams.	31.58%	6
Expand intensive outpatient services (extended Intensive Outpatient Programs for youth, day treatment programs, detox centers, etc.).	31.58%	6
Expand drop-in centers for individuals that struggle with mental health and/or substance use.	31.58%	6
Provide respite care and language-appropriate navigation supports for parents with children who experience a behavioral health crisis (5150, psychiatric emergency services, hospitalization, etc.).	21.05%	4
Total Respondents: 19		

APPENDIX 5. MHSA THREE-YEAR PLAN FUNDING SUMMARY

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Service Act (MHSA) Budget

Fiscal Year 2023-24

Community Services and Supports (CSS)			
Service Category	Program	BHRS Staff/Agency	TOTAL FY 23-24
Full Service Partnership (FSP)	**Children and Youth (C/Y)**		
	Integrated SAYFE	Edgewood	$933,481
	Comprehensive C/Y "Turning Point"	Edgewood	$2,518,639
	Out-of-County Foster Care	Fred Finch	$180,802
	Transition Age Youth (TAY)		
	Enhanced Education (TAY)	Caminar	$210,413
	Comprehensive TAY "Turning Point"	Edgewood	$2,732,836
	Adult & Older Adult		
	Adult and Older Adult FSP	Telecare	$2,216,135
	Adult and Older Adult FSP	Caminar	$727,424
	Assisted Outpatient Tx (AOT) FSP	Caminar; BHRS Staff	$1,226,191
	FSP Increases	TBD	$2,000,000
	Embedded South County FSP	Mateo Lodge	$150,535
	Care Courts FSP	TBD	$2,812,334
	Flexible Funds		
	C/Y/TAY FSP Flex Funds	BHRS	$375,000
	Adult/Older Adult FSP Flex Funds	BHRS	$1,380,000
	Housing Supports		
	TAY Supported Housing	Mental Health Association	$447,283
	Telecare Adult and Older Adult FSP Housing	Telecare	$1,519,394
	Caminar FSP/AOT Housing Support Program	Caminar	$581,637
	FSP Housing Increases	TBD	$2,404,290
	Board and Care	Various	$3,142,969
	Adult/Older Adult Supported Housing Services	Mental Health Association	$222,040
		TOTAL FSP	**$25,781,403**
General System Development (GSD)	**Substance Use Integration**		
	Substance Use Providers	Various; BHRS Staff	$742,955
	Substance Use Residentials (Youth and Adults)	HR360; TBD	$635,820
	Recovery Support Services	VoR	$245,047
	The Cariño Project – SU Services (80%CSS)	El Centro de Libertad	$44,000
	Older Adult System of Care		
	OASIS; hoarding resources	BHRS Staff	$977,195
	Senior Peer Couseling (50% CSS)	Peninsula Family Services	$150,095
	Criminal Justice Integration		
	Pathways, Court Mental Health	BHRS Staff; MHA	$220,564
	Criminal Justice Restoration and Diversion	BHRS Staff	$250,000
	Pathways, Housing Services	Life Moves	$125,718
	Other System Development		
	Pre-to-Three Initiative (Child Welfare Partners)	BHRS Staff	$677,598
	Puente Clinic	BHRS Staff	$457,736
	Trauma-Informed Interventions (NMT)	Various; MHA	$883,838
	EBP Clinicians	BHRS Staff	$1,824,235
	School-based MH	BHRS Staff	$317,319
	Crisis Management	BHRS Staff	$284,340
	Peer and Family Partner Support		
	Peer Workers and Family Partners	BHRS Staff	$2,033,683
	OCFA Stipends	MHA; BHRS	$45,609
	Multicultural Wellness Center	One EPA	$220,956
	The California Clubhouse	California Clubhouse	$395,716
	Peer Support; Supported Employment	Heart and Soul; TBD	$1,050,124
	Primary Care Integration		
	Primary Care Interface (20% CSS)	BHRS Staff	$196,782
	Ravenswood Family Health Center (40% CSS)	Ravenswood	$18,082

Mental Health Service Act (MHSA) Budget

Fiscal Year 2023-24

	Infrastructure Strategies		
	IT and Support Staff	BHRS Staff	$2,853,018
	Communications + Language Services	Various	$257,138
	Contractor's Association	Caminar	$218,670
	CSS Evaluations	AIR, PWA, AHDS	$217,627
	CSS Planning	Various	$151,952
	CSS Admin	BHRS Staff	$740,449
		GSD	**$16,236,265**
Outreach and Engagement (O&E)	Family Assertive Support Team (FAST)	Mateo Lodge	$373,768
	Coastside Multicultural Wellness (20% CSS)	ALAS	$86,275
	Adult Resource Management (ARM)	BHRS Staff	$1,823,274
	Housing Locator, Outreach and Maintenance	TBD	$1,075,000
	HEAL Program - Homeless Outreach	BHRS Staff	$325,000
	SMC Pride Center (35% CSS)	StarVista	$267,718
		TOTAL O&E	**$3,951,035**
		GRAND TOTAL CSS	$45,968,702
		Percent FSP (51% required)	56%
		Percent CSS (76% target)	**76%**

Workforce Education and Training (WET)			
	System-wide Training	BHRS Staff; Various	$1,500,000
	Recruitment/Retention Program	CalMHSA; Various	$500,000
	Training for/by Consumer (LEA, Advocacy Academy, Peer Leadership)	OCFA Various	$280,000
		TOTAL WET	$2,280,000

Capital Facilities and Technology Needs (CFTN)			
	Client Devices	T-Mobile Government	$330,000
	Client Device Applications (Apps)	PDT, Wysa	$300,000
		TOTAL CFTN	$630,000

Prevention and Early Intervention (PEI)			
Service Category	Program	BHRS Staff/Agency	TOTAL FY 23-24
Prevention & Early Intervention	Early Childhood Community Team (ECCT)	StarVista	$483,496
	Community Interventions for School Age & TAY		
	Trauma-Informed Services for Youth	Latino Commission; Puente de la Costa Sur; StarVista; YMCA	$520,000
	Brief Intervention Model (INSPIRE)	DCYHC	$100,000
	Youth Crisis Response (Hotline + Youth S.O.S)	StarVista	$1,038,911
Prevention	Trauma-Informed Systems (Ages 0-5)	First5 SMC	$150,000
	Community Outreach, Engagement and Capacity Building		
	Substance Use Prevention	TBD; BHRS Staff	$577,305
	Office of Diversity and Equity	BHRS Staff	$483,247
	Health Equity Initiatives	Co-chairs; BHRS Staff	$333,739
	Health Ambassador Program	BHRS Staff	$165,024
	Health Ambassador Program - Youth	StarVista	$304,115
	Parent Project	OneEPA, StarVista, PCRC; BHRS Sta	$288,787
Recognition of Early Signs of MI	Youth and Adult Mental Health First Aid	OneEPA, PCRC, StarVista, HOPE	$322,291
Stigma Discrimination and Suicide Prevention	Digital Storytelling and Photovoice	BHRS Staff; YLI	$281,685
	Mental Health Awareness; Be the ONE	BHRS Staff; CalMHSA	$175,486
	SMC Suicide Prevention Roadmap	BHRS Staff; CalMHSA	$205,486

Mental Health Service Act (MHSA) Budget

Fiscal Year 2023-24

Early Intervention	SMART	American Med Response West	$134,529
	Primary Care Based (80% PEI)	BHRS Staff; Ravenswood	$1,104,276
	Early Psychosis	Felton Institute	$589,164
	Crisis Response (Adult S.O.S.)	StarVista	$650,000
Access & Linkage to Treatment	North County Outreach	HealthRight 360	$348,198
	East Palo Alto Outreach	One EPA	$222,569
	Coastside Community Engagement (80%PEI)	ALAS; YLI	$356,026
	SMC Pride Center (65% PEI)	StarVista	$497,191
	allcove Youth Drop-In Center	Peninsula Health Care District	$500,000
	Senior Peer Counseling (50% PEI)+ OA Outreach	Peninsula Family Service	$413,727
	PEI Admin	BHRS Staff	$439,752
	PEI Planning	Various	$170,207
	PEI Evaluation	AHDS; Alison H.	$367,662
		GRAND TOTAL PEI	$11,222,873
		Percent Ages 0-25 (51% required)	60%
		Percent PEI (19% target)	**19%**

Innovations (INN)			
	Social Enterprise	Daly City Partnership	$522,148
	PIONEERS	HR360 AARS	$238,220
	Adult Residential In-home Support Element (ARISE)	Mental Health Association	$330,000
	Mobile Behavioral Health - Farmworkers	Ayudando Latinos a Sonar (ALAS)	$485,000
	Music Therapy for Asian/Asian Americans	NEMS/Creative Vibes Therapy	$255,000
	Recovery Connection Drop-In Center	Voices of Recovery	$500,000
	Admin/Overhead	BHRS	$215,000
	INN Evaluation	RDA; AIR; CCPA (Joyce Chu)	$231,000
		TOTAL INN	$2,776,368

Obligated Funds			
	Total Reserve		28,362,318
	Innovation- Approved Projects		9,131,924
	Innovation 5% - Unallocated		4,615,845
	Housing Funds		4,286
	One-Time Spend Plan (CFTN)		6,310,000
	One-Time Spend Plan (Housing)		16,000,000
	One-Time Spend Plan (System Transformation)		3,500,000
		TOTAL Obligated	67,924,373

		Total Ongoing Budget	$62,877,944
		One-Time	$25,814,286
		MHSA GRAND TOTAL BUDGET	**$88,692,230**

APPENDIX 6. WET THREE-YEAR PLAN, FY 2023-26

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

San Mateo County Behavioral Health & Recovery Services | Mental Health Services Act **Workforce Education and Training Plan Fiscal Years 2023-2026**

Overview

The San Mateo County Behavioral Health and Recovery Services (BHRS) Mental Health Services Act (MHSA) Three-Year Workforce Education and Training (WET) Plan will **guide implementation of WET strategies for fiscal years 2023-2026**. The WET Plan aligns with California Department of Health Care Access and Information (HCAI) 2020-2025 WET Five-Year Plan and Regional Partnership guidelines for implementing WET programs statewide.

The WET Plan is divided into two sections:

1. Workforce Recruitment and Retention Plan
2. Workforce Training Plan

Stakeholder Engagement Process

The WET Plan was developed during the comprehensive Community Program Planning (CPP) process for the County's MHSA Three-Year Plan, which involved diverse groups of BHRS staff, contracted agencies, and peers and family members in identifying needs, recommending strategies to meet the needs, and prioritizing those strategies. **BHRS sought input on WET needs and strategies in two phases**:

1. BHRS gathered input on behavioral health workforce needs and strategies in community input sessions for the County's broader three-year MHSA plan. See the MHSA Three-Year Program and Expenditure Plan, FY 2023-26 for a list of the community input activities.

2. BHRS contracted a consultant to carry out **five virtual input sessions on workforce recruitment and retention** and an **online survey on workforce training priorities**. These methods offered an opportunity for in-depth conversation and feedback to shape the WET Plan.

WET Implementation

As part of the CPP, **the MHSA Steering Committee selected Behavioral Health Workforce as the top priority for MHSA investment**. As a result, BHRS will dedicate funding for workforce strategies, using the WET Plan as a guide. BHRS recognizes that some strategies require system-level changes—

comprehensive change or innovation that may require involvement and decision-making from multiple partners, including unions—while some are low-hanging fruit—changes within the current system (e.g., a new program or process) that would have immediate, positive impact on the workforce. The WET Plan includes a range of short-term to long-term strategies, understanding that some strategies will require a multi-phase implementation timeline.

The WET team currently includes three positions: WET Director, WET Internship Program Coordinator, and Community Program Specialist – Training Support. WET operates under the BHRS Office of Diversity and Equity (ODE) and is supervised by the ODE Director. This organizational structure enhances the focus of WET to embed cultural humility, apply an equity lens, support the core values of MHSA, and allow for a systemic approach to behavioral health workforce strategies.

Workforce Recruitment and Retention Plan

Stakeholder Engagement

WET input sessions (see table below) focused on **two primary questions** related to workforce recruitment and retention:

- What strategies would support people of diverse backgrounds to *enter* the behavioral health workforce?
- What would encourage staff to *remain* in the behavioral health workforce?

WET Input Session	Stakeholder Representation
1. Adult Leadership	• BHRS leadership and management of treatment programs for adults
2. AOD Providers Group	• BHRS Alcohol and Other Drug (AOD) staff and contracted providers
3. Diversity and Equity Council (DEC)	• Health Equity Initiative co-chairs • BHRS staff • Contracted providers • Peers
4. Lived Experience Education Workgroup (LEEW)	• Clients and family members, many who have participated in the County's Lived Experience Academy, supported by the Office of Consumer and Family Affairs (OCFA)
5. Youth Leadership	• BHRS leadership and management of early intervention and treatment programs for children and youth

Input session participants were invited to offer comments verbally, in the meeting chat, or on an anonymous feedback document. Comments were also gathered via an online WET survey to invite feedback from a broader audience—while the survey focused on training priorities, there was an optional section for staff to share suggestions about workforce recruitment and retention.

Strategy Prioritization

Input session and open-ended survey comments were organized into 11 categories (shown below alphabetically) based on topics raised by stakeholders and research on factors that influence behavioral health workforce retention.[1]

1. Career advancement
2. Compensation and benefits
3. Hiring process and requirements
4. Financial incentives
5. Organizational culture and management
6. Peer engagement and leadership
7. Pipeline
8. Staff wellness, support, and engagement
9. Training and experience
10. Workload
11. Work flexibilities

Next, strategies in each category were consolidated from stakeholder suggestions. Based on this analysis, **BHRS combined the categories as follows and put forward 11 strategies for the MHSA Steering Committee to prioritize**.[2]

1. Compensation and benefits
2. Financial incentives
3. Peer engagement and leadership
4. Pipeline, hiring, and career advancement
5. Staff wellness, support, and engagement
6. Workload and work flexibilities

The MHSA Steering Committee met on May 4, 2023, and **23 members each selected three strategies for BHRS to implement over the next three years**. The table below shows the WET strategies in order of priority from the MHSA Steering Committee. Next, there is a description of stakeholder input in each category and more detail about the components of each strategy.

[1] MHSA Stipend Program Retrospective Study Highlights: Retention; California's Children's Mental Health Workforce

[2] Note: "Training and experience" was designated as a separate section of the WET Plan and was therefore not included in the six priority areas. Feedback related to "organizational culture and management" was routed to the ODE team in charge of the department's Multicultural Organization Development (MCOD) Action Plan.

Summary of MHSA Steering Committee Priorities

WET Strategy *(Number of Selections as a Priority Strategy)*	**Category**
Implement recruitment and retention financial incentives for staff and contracted providers *(7)*	Financial incentives
Invest in support, retention, and leadership development of peers and family members *(7)*	Peer engagement and leadership
Implement supports for direct service staff, including peers, to advance in their careers, specifically BIPOC staff *(6)*	Pipeline, hiring, and career advancement
Research, plan, and implement compensation and benefits that are aligned with competing agencies and neighboring counties *(4)*	Compensation and benefits
Create a pipeline program focused on increasing Asian/Asian American and Black/African American behavioral health staff *(4)*	Pipeline, hiring, and career advancement
Target recruitment activities to reach black, indigenous, people of color (BIPOC) communities *(4)*	Pipeline, hiring, and career advancement
Explore opportunities for alternative and flexible schedules and remote work *(4)*	Workload and work flexibilities
Create more entry-level positions and internships for students of diverse backgrounds; streamline process to hire interns *(2)*	Pipeline, hiring, and career advancement
Streamline BHRS hiring process to enhance recruitment[3]	Pipeline, hiring, and career advancement
Examine and adjust caseload size and balance, particularly for bilingual staff *(2)*	Workload and work flexibilities
Expand type, flexibility, and access to staff wellness and engagement opportunities *(2)*	Staff wellness, support, and engagement
Address extra help and contracted positions, especially for those that interface with the community *(1)*	Pipeline, hiring, and career advancement

[3] Note: This was pulled out from the above strategy after the Steering Committee meeting in order to distinguish between improvements to the overall hiring process and improvements in the intern hiring process.

Category 1: Compensation and Benefits

Summary of stakeholder input

Staff,[4] contractors, and peers highlighted competitive salaries that enable them to afford living in San Mateo County as a core issue affecting both retention and recruitment. They noted pay differentials between San Mateo County BHRS and neighboring counties, between BHRS and other large healthcare employers in the county such as Kaiser, between BHRS and community-based organizations (CBOs), and between mental health and alcohol and other drug (AOD) counselors. Staff called attention to the need for higher pay for bilingual staff, observing that retention of bilingual staff is particularly challenging. In addition to increasing compensation, staff suggested that strengthening benefits such as retirement plans and providing vouchers to assist with the cost of housing could support staff recruitment and retention.

"It's about wages and benefits—we need to be able to pay our staff living wages and benefits, or we won't be able to support our staff."

Strategy	Components
1.1 Research, plan, and implement compensation and benefits that are aligned with competing agencies and neighboring counties.	• Increase cost of living adjustments (COLAs) • Increase pay for bilingual staff (and explore adding languages that qualify to receive bilingual pay) • Strengthen retirement/pension plans • Increase equity between disciplines (e.g., mental health clinicians, AOD counselors, nurses, medical doctors) • Increase contract amounts for contracted providers to pay higher wages • Provide and/or support BHRS staff with housing, below market rate housing, and/or housing vouchers

Category 2: Financial Incentives

Summary of stakeholder input

After compensation, financial incentives (monetary benefits that encourage staff to enter or remain in the workforce) were a frequent suggestion for improving both retention and recruitment. Bonuses were the most commonly mentioned type of financial incentive, including bonuses upon hire and retention bonuses for staff who have worked for a certain number of years. Loan repayment was also commonly mentioned as an attractive incentive. Staff also suggested funding for undergraduate and graduate education, credential renewal, and other trainings. Staff emphasized the importance of providing financial incentives for individuals from diverse backgrounds, particularly Black, Indigenous, and other people of color (BIPOC) and those who are bilingual to enter and advance

"There seems to be more organizations providing starting bonuses, which are an attractive strategy for recruitment."

[4] Note: To be concise, the term "staff" is used throughout to refer to all levels of staff, including leadership, managers, supervisors, and direct service staff.

in the field. They also raised a need to improve communication, promotion, and support for existing County-run and federal financial incentives (e.g., ensuring staff know how to apply, simplifying application processes, and building time into staff meetings to apply).

Strategy	Components
2.1 Implement recruitment and retention financial incentives for staff and contracted providers.	• Offer starting bonuses, including higher bonuses for bilingual staff • Offer retention bonuses • Expand educational loan repayment programs • Promote and support staff in applying for existing loan repayment opportunities

Category 3: Peer Engagement and Leadership

Summary of stakeholder input

"There is a need for mentoring and coaching for peers and family members to fully participate in BHRS operations, program development, and oversight."

Peers and staff underscored that engaging people with lived experience in the workforce is critical to effective service delivery. At the same time, they observed that stigma and lack of information prevent BHRS and contractors from integrating peers consistently and to their full potential. They recommended training for BHRS and contractors on consumer culture, implicit bias, and hiring and working with peers—this is included in the Workforce Training Plan below.

Other recommended strategies included increasing support for peers who may be interested in entering or advancing their careers in the behavioral health field and ensuring that peers can meaningfully engage in BHRS advisory and decision-making spaces. On a system level, supporting CBOs to set up their infrastructure to align with CalAIM reform and bill Medi-Cal for peer specialists was suggested—this was included in another component of the MHSA Three-Year Plan and is therefore not included as a WET strategy.

Strategy	Components

3.1 Invest in support, retention, and leadership development of peers and family members.	• For peers who have engaged with the County through the Lived Experience Academy (LEA), Advocacy Academy, and/or LEEW:
	  ○ Support peers to meaningfully engage in BHRS advisory and decision-making spaces (e.g., mentoring to meaningfully participate in committees and workgroups)
	  ○ Enhance career development support (e.g., scholarships and support for peer certification, shadowing/volunteer opportunities, "peer career track" cohort with hiring workshops and

	support, social emotional support for employed peer workers) ○ Provide opportunities for networking and relationship building • Ensure financial viability of working as a peer or family support worker (e.g., competitive pay, training/benefits counseling related to working while receiving supplemental security income, financial incentives for career advancement) • Engage new peers through peer-led outreach in clinic and community spaces

Category 4: Pipeline, Hiring, and Career Advancement

Summary of stakeholder input

Staff, contractors, and peers highlighted the need to create pathways for people with diverse backgrounds and lived experience to enter and advance in the behavioral health field.[5]

- **Pipeline**: Stakeholders commonly suggested pipeline programs to engage high school and undergraduate students in school and non-academic settings (e.g., mentorship programs, summer programs, bilingual or Spanish language pipeline programs, and expanding the County's existing Health Ambassador Program for Youth). Pipeline programs could also include outreach to adults who might be interested in a career change. There was an emphasis on programs for individuals who identify as Asian/Asian American or Black/African American, as these groups are underrepresented among BHRS staff.
- **Hiring**: Efficient hiring processes are critical to workforce recruitment. Staff reflected that the hiring and onboarding process (e.g., background checks, hiring contracts) is often lengthy, which disincentivizes staff who may have other job offers or cannot afford to be unemployed for the length of the hiring process. Staff observed that the use of limited term and extra help contracts has been a barrier to both recruitment and retention and there is a need for greater job stability. They also emphasized that creating more entry-level positions and internships, and reducing barriers to hiring interns immediately after graduation, would improve recruitment of staff from diverse backgrounds.

  "If I was looking for a job, I can't wait 30 days to be hired. I have an 8-year-old to feed."
- **Career advancement**: Staff recommended providing supports for direct service staff, specifically BIPOC staff, to pursue advanced degrees/licensure/credentials while working and to receive mentorship and support to enter leadership positions.

[5] To be successful, these strategies should incorporate financial incentives such as scholarships and stipends and be implemented in the context of competitive pay.

Strategies	Components
4.1 Create a pipeline program focused on increasing Asian/Asian American and Black/African American behavioral health staff.	• Develop partnerships and programs with local and neighboring academic and non-academic programs (e.g., high schools, community colleges, universities, adult schools, local wellness centers, nonprofits, places of worship, promotores programs) • Consider outreach to mature workers interested in a career change • Expand the Health Ambassador Program for both youth and adults *(included in the MHSA Three-Year Plan under Youth Needs)*
4.2 Target recruitment activities to reach black, indigenous, people of color (BIPOC) communities.	• Ensure racial equity lens is used in job postings • Partner with BIPOC-focused communities and student organizations and networks
4.3 Create more entry-level positions and internships for students of diverse backgrounds; streamline process to hire interns.	• Research, plan, and implement new entry-level positions and internships • Integrate processes to enable BHRS to hire trainees/interns immediately after graduation
4.4 Streamline BHRS hiring process to enhance recruitment.	• Expedite hiring and onboarding process • Explore hiring a recruiter • Allow for hiring clinicians with alternative licenses (e.g., licensed professional clinical counselors—LPCC) • Ensure job postings include a salary range and benefits • Include staff/team members in hiring interviews to ensure a good fit to the team
4.5 Address extra help and contracted positions, especially for those that interface with the community.	• Explore permanent, benefited positions for community-facing work • Explore other means for creating consistency and leadership for community-facing work
4.6 Implement supports for direct service staff, including peers, to advance in their careers, specifically BIPOC staff.	• Offer incentives (e.g., scholarships) to pursue advanced degrees/licensure/credentials • Increase mentorship and support for BIPOC staff to enter leadership positions

Category 5: Staff Wellness, Support, and Engagement

Summary of stakeholder input

Staff and contractors reflected that along with the financial and administrative factors influencing retention, staying in a job long-term requires feeling appreciated and supported. They suggested that BHRS increase formal and informal opportunities for staff recognition, mentoring, and relationship building. They called attention to the need to address pandemic trauma and prevent burnout through team-based

"One thing that's made me stay is I've had opportunities to build a lot of relationships."

wellness activities and easy-to-access behavioral health services, treatment, and trainings (e.g., trauma stewardship, mindfulness, and sensory/movement modalities).

"People need to feel safe and heard as well as knowing this may be a place where personal development is possible."

Staff highlighted the importance of feeling heard, respected, and trusting that leadership will support and advocate for them. They recommended strategies to increase diversity at all levels of the organization and support trauma-informed and culturally responsive leadership. Because these strategies point to agency-wide culture and management, this feedback was elevated to the ODE team leading the BHRS Multicultural Organization Development (MCOD) plan.

Strategy	Components
5.1 Expand type, flexibility, and access to staff wellness and engagement opportunities.	• Provide flexible team wellness budgets for staff appreciation and wellness activities • Offer staff mentoring programs, particularly for BIPOC staff • Improve availability and access to behavioral health supports for staff, including Employee Assistance Programs (EAP) and other supports • Increase opportunities for relationship building (e.g., cohorts of new employees, welcome events for interns, mixer events across teams, contracted provider networking events)

Category 6: Workload and Work Flexibilities

Summary of stakeholder input

A key component of employee wellbeing is having a manageable workload. Staff shared that they are frequently required to take on more work than one person can reasonably do well. For direct service staff, this is often driven by caseloads—not only caseload sizes, but also the intensity of those caseloads. Staff acknowledged that bilingual staff often carry higher caseloads.

"Stress and burnout is the most important issue. Until you create an environment that helps, instead of giving high caseloads, I don't see people staying very long—it's stressful, compassion fatigue sets in."

In addition to addressing workload issues, staff recommended flexible work schedules including part-time opportunities and continuation of remote work schedules as appropriate (e.g., for staff who do not interface with clients), and noted that several competing agencies offer these types of flexibilities. Staff also suggested that having greater flexibility to take time off for mental health and/or family reasons would promote wellbeing and retention.

Strategies	Components

6.1 Examine and adjust caseload size and balance, particularly for bilingual staff.	• Develop caseload standards and methods for monitoring caseloads, with special attention paid to those providing bilingual services • Analyze and improve workflows
6.2 Explore opportunities for alternative and flexible schedules and remote work.	• Offer opportunities to work less than 40 hours/part-time • Offer options to work at different times/days as appropriate • Continue telework schedules as appropriate • Increase flexibility in offering time off for staff experiencing stress or burnout

Workforce Training Plan

Stakeholder Engagement

The online WET training survey **sought feedback from staff, contractors, and peers about training priorities**. Specifically, the survey asked what BHRS does well and areas for improvement, training topics of interest, and how BHRS can support staff to access trainings and apply knowledge in practice.

BHRS emailed the survey to over 500 staff and contractors and promoted it in BHRS staff meetings from late March to late April 2023.

- **96 responses** were received.
- **Half of respondents (50%) were direct service staff**, about a quarter (24%) were program managers/supervisors, 14% were administrative staff, 8% were executive leadership, and 4% were in a peer/family support role.
- Of the 75 respondents who reported their race/ethnicity, **the largest group identified as White (47%),** followed by Latino/a/x or Hispanic (32%), and Asian (20%). Black/African American staff made up 8% of responses, 7% identified as another race or ethnicity, 4% identified as Native American, American Indian, or Indigenous, and 3% identified as Native Hawaiian or Pacific Islander.
- Respondents were **evenly split between 0-3 years, 4-9 years, and 10 or more years** in their role.

Strategy Prioritization

Training is a key factor both for staff retention and maintaining a high-quality workforce. The Workforce Training Plan includes overarching strategies to improve training availability, experience, and application, as well as priority training topics. BHRS developed workforce training strategies based on common barriers and suggestions for improvement from staff in the WET training survey and WET input sessions. BHRS identified priority training topics based on the proportion of survey respondents that selected them.

Summary of Stakeholder Input

- **Training topics.** Staff suggested increasing the variety of trainings, including training on serving clients with complex needs for clinical, non-clinical, and administrative staff. Direct service staff most commonly voiced a need for more clinical training, particularly training in a variety of evidence-based practices that goes beyond introductory level courses and provides continuing education unit credits (CEUs). Several staff praised the strong focus on cultural humility training, and some requested more in-depth trainings in this area. Some also noted they appreciated having trainers from diverse backgrounds and suggested incorporating more trainers with lived experience. Peers and staff also emphasized the need to train BHRS staff and contractors on consumer culture and hiring/working with peers. Trainings in the categories of "behavioral health crisis management, assessment, and prevention" and "areas of specialization" had the most training topics that were prioritized by more than 50% of survey respondents.

- **Training access.** Survey responses suggest that not all staff learn about BHRS trainings with enough advance notice. Many survey respondents reported difficulty finding time to attend trainings given their workloads and schedules. To address these barriers, staff suggested advertising trainings farther in advance, offering trainings on multiple days and times, creating a structured training calendar, and introducing more self-paced trainings. Staff appreciated the existing support for educational leave and reimbursement for external trainings and suggested helping staff apply for approval and extending this benefit for contractors. They also recommended increasing opportunities for staff and contractors to be invited to trainings run by BHRS and CBOs. Several staff commented that they appreciated the transition to virtual training; moving forward, about two-thirds of survey respondents preferred a combination of remote and in-person training options, while about a quarter preferred all remote trainings.

  "Even when trainings are advertised in advance, the slots fill up quickly. If or when a space is opened up it is difficult to get supervisor approval for the training if the training is the next day or within the next few days because the request is short notice."

- **Application of knowledge and skills**. Staff preferred ongoing consultation/coaching, follow-up/refresher trainings, and interactive trainings to help them apply skills taught in trainings. Other suggestions were to assign staff "buddies" or mentors, particularly for self-paced trainings, and to allot time during the workday for staff to review and study concepts learned in trainings.

Training Strategies

Strategies	Components
1. Strengthen scheduling and communication about BHRS trainings.	• Inform staff and contractors of trainings farther in advance • Offer trainings on multiple days and times • Compile and share a structured training calendar • Consider productivity standards when scheduling trainings • Add self-paced trainings to help with scheduling conflicts
2. Increase the type, level, and frequency of training offered.	• Increase topics and variety of clinical trainings • Increase upper-level (beyond introductory) trainings on clinical and cultural humility topics • Increase training opportunities for administrative staff • Support staff in accessing external trainings or conferences
3. Increase the number of trainings that offer CEUs.	• Certify existing trainings to provide CEUs • Create a set schedule for trainings required for licensure (e.g., semi-annual Law and Ethics trainings)
4. Enhance support for staff in applying knowledge and skills from trainings.	• Enhance clinical consultation and coaching (e.g., consultation with clinical experts, including consultation groups led by BIPOC clinicians) • Increase the number of follow-up/refresher trainings • Prioritize interactive trainings
5. Enhance BHRS and contractors' capacity to hire and work with peers.	• Train supervisors responsible for hiring and supervision of peer and family support workers • Train all staff on the role of peer and family support workers • Involve peers in developing, reviewing, and presenting content for these trainings

Training Topics

The priority topics below represent the **top three selections** in each training category on the WET survey. See the Appendix for the full data on training priorities. The WET team will use the priority topics, survey data, and write-in responses to inform its training calendar for fiscal years 2023-26.

Training category	Priority topics
Areas of specialization	• Integrated care for complex clients • Treating eating disorders • Human trafficking
Behavioral health crisis management, assessment, and prevention	• Deescalating a crisis • Advancing suicide prevention and management for diverse clients • Assessing and managing risk of suicide
Culturally informed practices	• Movement therapy • Drumming • Storytelling

Training category	Priority topics
Evidence-based practices	● Trauma-focused cognitive behavioral therapy (CBT) ● Motivational interviewing ● Dialectical behavior therapy (DBT)

Peer trainings	● *Training for individuals with lived experience* [6]
	  ○ Working with people who are unhoused
	  ○ Peer work in crisis care
	  ○ Peer work with justice-involved individuals
	● *Training for BHRS staff and contractors* [7]
	  ○ Implicit bias and behavioral health stigma
	  ○ Hiring and working with peers
	  ○ Supervision of peer workers
	  ○ Consumer culture

Multicultural organization development, diversity, equity, and inclusion (DEI)	● Supporting diverse staff engagement ● Facilitating dialogue on DEI ● Giving and receiving responsive feedback

[6] The San Mateo County Office of Consumer and Family Affairs (OCFA) oversees training and leadership development for peers/family members. The survey received only four responses from individuals who identified as being in a peer/family support role, therefore there is a need to enhance input from peers/family members to inform training priorities. BHRS will route input from peers/family members to OCFA for consideration and for them to continue engaging peers/family members in prioritizing training topics.

[7] These recommendations are from the WET input session discussions, as this was not asked on the survey.

Appendix

Data on Training Priorities

Areas of specialization (83 total responses)	Number	Percent
Integrated care for complex clients	62	75%
Treating eating disorders	52	63%
Human trafficking	44	53%
Other	24	29%
Write-in responses and input session feedback: Supporting undocumented individuals/families and immigration trauma (several mentions); language training if a need is identified (e.g., improving Spanish language skills for staff who already have some proficiency); how to assist unhoused clients utilizing county resources, public benefits for unhoused clients; working with clients on the autism spectrum (2 mentions); training on the new DSM; training for addressing PTSD, personality disorders (2 mentions), psychotic symptoms, bipolar disorder, co-occurring disorders (2 mentions) and substance use disorders (several mentions); emotion regulation; opiate crisis training and Narcan; smoking cessation; medication management with a focus on new medication options; mental health in older adults; impacts of social media.		

Behavioral health crisis management, assessment, and prevention (85 total responses)	Number	Percent
Deescalating a crisis situation	62	73%
Advancing suicide prevention and management for diverse clients	52	61%
Assessing and managing risk of suicide (for clinicians)	48	56%
Postvention support	31	36%
Access to lethal means counseling	13	15%
Other	7	8%
Write-in responses and input session feedback: suicide and violent behavior risk assessment and documentation for all staff; managing risk with clients who are actively self-harming; management of verbally abusive clients, family members, community members; 5150 process; training in firearm safety and working with clients on lethal means restriction; laws and ethics related to suicidal ideation and danger to self and others.		

Culturally informed practices (75 total responses)	Number	Percent
Movement Therapy	51	68%
Drumming	36	48%
Storytelling	34	45%
Healing Circles	32	43%
Medicinal Plants	21	28%
Other	14	19%
Write-in responses and input session feedback: relaxation techniques such as yoga, meditation, breathing, and progressive muscle relaxation; tai-chi; sound healing; art therapy such as painting,		

drawing, clay; singing; dance therapy; pow wow, sweat lodge, and spiritual practices; African-American and Latinx specific practices.

Evidence-based practices (82 Total responses)	Number	Percent
Trauma Focused CBT (TF-CBT)	47	57%
Motivational Interviewing (MI)	39	48%
Dialectical Behavior Therapy (DBT)	37	45%
Mindfulness-Based Substance Abuse Treatment (MBSAT)	28	34%
Eye Movement Desensitization and Reprocessing (EMDR)	25	30%
Acceptance and Commitment Therapy (ACT)	23	28%
Brief Strategic Family Therapy (BSFT)	9	11%
Other	18	22%
Write-in responses and input session feedback: CBT for psychosis; CBT for insomnia; DBT, family-based treatment (FBT); Internal Family Systems (IFS) (2 mentions); WRAP (2 mentions); attachment-based therapies such as interpersonal psychotherapy (IPT); polyvagal theory; emotional freedom techniques (EFT); family systems therapy; Brain spotting; other evidenced-based trauma therapies for complex clients; expressive arts therapy; harm reduction; PITH family therapy; Youth Acceptance Project-Family Builders;); contingency management; recovery/resiliency model of care components.		
There was a collection of write-in responses and input session feedback related to clinical processes and tools: telehealth and options for interventions; web tools and apps for therapy or notetaking; clinical documentation training such as how to improve progress notes; treatment planning (e.g., incorporating CANS and other tools into practice; new laws and legislation that govern mental health; processes for accessing BHRS services; referring clients to assistance with health insurance and public benefits.		

Peer trainings (70 total responses)	Number	Percent
Working with persons who are unhoused	47	67%
Peer work in crisis care	38	54%
Peer work with justice-involved individuals	28	40%
Supervision of peer workers	27	39%
Other	11	16%
Write-in responses and input session feedback: Community inclusion; Recovery 101; creating opportunities for families to engage in supported creative experiences; parenting, family support; support for peer certification; working with youth on the autism spectrum; working with CPS; Motivational Interviewing; non-violent communication; working with human trafficking victims; clinical trainings		

Multicultural organization development, diversity, equity, and inclusion (DEI) (78 total responses)	Number	Percent
Supporting diverse staff engagement	36	46%

Facilitating dialogue on diversity, equity, and inclusion	35	45%
Giving and receiving responsive feedback	35	45%
Creating trust among teams	28	36%
Other	20	26%
Write-in responses and input session feedback: Training for supervisors on supervising staff; supporting undocumented individuals and families; training on how to support LGBTQ+ clients in coming out to their families, friends, etc.; hiring practice that attract multi-cultural staff; humility as a whole; community inclusion; how to be anti-racist; advanced cultural humility training (e.g., "calling in"); communication and addressing conflict; working with multi-generational staff; embracing diversity beyond ethnicity, gender and sexual orientation; guidance for practicing MCOD goals alongside other providers when working with clients involved in the legal system (like CFS); trainings with outside trainers (such as Dr. Ken Hardy, Dr. Joy DeGruy, and Tim Wise).		

Additional Survey Data

Ensuring knowledge and skills are applied (82 total responses)	Number	Percent
Learning collaboratives	61	74%
Follow-up/refresher trainings	58	71%
Ongoing consultation/coaching	46	56%
Interactive trainings (e.g., scenario based, role plays)	26	32%
Technical assistance for implementation	26	32%
Other	8	10%
Write-in responses and input session feedback: experiential training; mentoring; one-way mirror in-vivo coaching; breakout room/small group discussions; role-plays; case study reviews; time allotted during the regular work day to read/study/process the newly learned skills		

Barriers (84 total responses)	Number	Percent
It is hard to fit in trainings with existing workload	54	64%
Trainings do not provide Continuing Education Unit (CEU) credits	42	50%
Trainings are not advertised far enough in advance	32	38%
Trainings are not offered at times of day that fit with my schedule	26	31%
Training slots fill up	17	20%
It is difficult to get approval to attend trainings	6	7%
I have not experienced barriers	12	14%
Other	22	26%
Write-in responses and input session feedback: difficult to get supervisor approval for training slots that open up with short notice; tech issues with trainings in LMS; trainings that get canceled if enough people do not show up; meeting productivity standards of the county for days when training is under 4 hours (i.e., 3.5 hours is almost half the work day, but not considered productive by county standards)		

APPENDIX 7. PEI REPORTING FRAMEWORK & CROSSWALKS

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Project Background

In June 2018, the California Mental Health Services Oversight and Accountability Commission updated the reporting requirements for the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA). Programs funded through the PEI component of MHSA, which is intended to prevent mental illness from becoming severe and disabling, can focus on prevention, early intervention, or a combination of both. The new reporting requirements focus on individual demographics, referrals and access to treatment, and individual outcomes.

San Mateo Behavioral Health & Recovery Services (BHRS) contracted with RDA Consulting (RDA) to provide outcome data planning and technical assistance for San Mateo County's PEI programs that provide some component of individual-level services.[1] The project aimed to identify a reporting framework in which PEI data and individual outcomes could be analyzed across all PEI-funded programs. This document outlines the PEI data collection and reporting framework that was developed through this process, highlights the key decisions points that were made to inform this framework, and provides visual summaries of how the currently funded PEI programs will be reporting individual data and outcomes based on this framework.

PEI Program Reporting

MHSA legislation requires counties to fund specific types of programs under the following program areas: prevention, early intervention, outreach for increasing recognition of early signs of mental illness, access and linkage to treatment, timely access to services for underserved populations, suicide prevention, and stigma and discrimination reduction. Funding will continue to be allocated in these program areas. Additionally, PEI programs must address three strategies and collect specified data in each of these strategies: Access & Linkage to Treatment, Timely Access to Services for Underserved Populations, and Stigma & Discrimination Reduction.

Key Decision Point

How PEI programs were categorized for data reporting purposes:

1. **Prevention Programs:** focus on *outreach and education*.
2. **Prevention and Early Intervention Programs:** include both an *outreach/education* component as well as early intervention *clinical services*.
3. **Early Intervention Programs:** primarily provide one-on-one early intervention *clinical services*.

MHSA PEI programs provide services on the spectrum of prevention and early intervention services, from outreach and education initiatives to programs that create entry ways into clinical early intervention services. For the purposes of this reporting framework and data collection activities, programs were categorized to reflect this spectrum of prevention and early intervention services: (1) Prevention Programs, (2) Prevention and Early Intervention Programs, and (3) Early Intervention Programs. The San Mateo County PEI funded programs included in this framework are listed in Table 1 by these three reporting categories and the required MHSA strategies.

[1] PEI programs that primarily provide awareness, referrals and system-change services are unable to collect unduplicated individual-level data and were not included in this PEI data collection and reporting framework.

Table 1. Programs by PEI Component and Strategies

PEI Component	PEI Program	Agency	PEI Strategies		
			Access & Linkage to Treatment	Timely Access to Services for Underserved Pop.	Stigma & Discrimination Reduction
Prevention	Health Ambassador Program (HAP)	BHRS			✓
	Youth Health Ambassador Program (Y-HAP)	StarVista			✓
	Mindfulness-Based Substance Abuse Treatment (MBSAT)	Puente de la Costa Sur, YMCA, and StarVista	✓		
	The Panche Be Youth Project	The Latino Commission	✓		
	Outreach Collaboratives*		✓		
	Stigma Reduction and Suicide Prevention*		✓		
Prevention & Early Intervention	Early Childhood Community Team (ECCT)	StarVista		✓	✓
	Project SUCCESS	Puente de la Costa Sur		✓	
	The Cariño Project	ALAS		✓	✓
	Peer Counseling	Peninsula Family Service		✓	✓
	Youth S.O.S.	StarVista	✓		
Early Intervention	Primary Care Interface	BHRS	✓	✓	
	re(MIND) Early Psychosis Program	Felton Institute	✓	✓	
	The Pride Center	StarVista	✓	✓	

*These programs did not receive technical assistance from RDA; these programs are primarily providing awareness and system change focused services and are not able to collect unduplicated individual-level data but, will report duplicated individuals reached, demographics, referrals and outcome data (i.e., post surveys).

PEI Data Collection Framework

This PEI data collection and reporting framework uses two standard reporting templates through which all PEI programs will report their data. It also includes individualized PEI Program Crosswalks that outline the specific reporting expectations for each program (see Appendix A for each program's crosswalk). This approach allows programs to clearly identify how their specific program data aligns with the overarching framework.

The standard reporting templates are: 1) the MHSA Annual Reporting Template, which includes preset sections for narrative and tables to report aggregate data, and 2) a PEI Data Template which includes preset spreadsheets for programs to report individual-level data. Each program's individualized crosswalk identifies the MHSA reporting requirements for:

1. Individuals served/reached and demographics
2. Referrals
3. Individual-level outcomes

Individuals Served, "Reached" and Demographics

Key Decision Points

How PEI programs will report unduplicated vs. duplicated data:

- **Unduplicated individuals served:** All programs identified at least one primary program component for which they will report the required unduplicated number of individuals served. A program may have more than primary component but, they must report an unduplicated count of individuals served for their program. For example, if a program's primary components are short-term clinical therapy and case management, an individual receiving both services would only be captured once in the unduplicated number of individuals served.
- **Individuals "reached":** Programs also identified components through which they may have a broader reach, such as outreach or educational activities. The number reported under this "reach" category does not need to be an unduplicated count. For example, if a program offers workshops as another program component, they can report on the number of workshops attendees over the course of the reporting period, which may include some duplicate individuals who attended multiple activities.
- **Demographics:** Programs will collect full demographic data on unduplicated individuals served through their primary program components. Full demographics will be reported in the standardized San Mateo County format, which addresses the MHSA PEI requirements and local community input received regarding how we ask sensitive questions regarding race, ethnicity, and language (REAL) and sexual orientation, gender identity, and expression (SOGIE). For individuals "reached", the program may collect a standardized shortened list of demographic data. For example, in group settings, such as workshops or classes, or at large events. Demographic information is not required for light-touch outreach activities.

Table 2. PEI Program Components for Individuals Served and "Reached"

PEI Component	PEI Program	Unduplicated individuals served through primary program component(s)	Individuals reached through other program components, may be duplicated
Prevention	Health Ambassador Program	Health ambassadors	Individuals reached through outreach and presentations
	Youth Health Ambassador Program	Cohort	Individuals reached through outreach and presentations
	Mindfulness-Based Substance Abuse Treatment	Youth cohort	Individuals impacted by community outreach/presentations, family members of youth, providers
	The Panche Be Youth Project	Youth	Family members
Prevention & Early Intervention	Early Childhood Community Team	Children receiving one-on-one services (including direct therapy) and participating in groups	Parents and caregivers in groups, teachers who receive consultations, children reached by consultations
	Project SUCCESS	Group services and one-on-one counseling	N/A
	The Cariño Project	Clinical services	Case management services and individuals reached through workshops, events, outreach, etc.
	Peer Counseling	One-on-one peer counseling and groups	N/A
	Youth S.O.S.	Mobile crisis response	Family members/caregivers of youth served, individuals reached through outreach/education
Early Intervention	Primary Care Interface	Counseling, case management, psychiatry	N/A
	re(MIND) Early Psychosis Program*	Early psychosis treatment and re(MIND) Alumni	Family members/caregivers
	The Pride Center	Therapy and case management	Peer groups, trainings, consultations

Referrals

Key Decision Points

How PEI programs will report on referrals:

- **Referrals into Early Intervention Programs:** Due to wide variety of services provided by PEI-funded programs, collecting extensive data on referrals into the PEI programs is not possible for prevention-focused programs. Therefore, referral to and enrollment into a PEI program will only be collected from Early Intervention Programs. Individuals enrolling into an Early Intervention Program will likely have a time period of untreated mental illness to report as part of a formal intake process. These Early Intervention Programs will also collect referral data into their programs and report on the MHSA requirements for the average duration of untreated mental illness and the interval between a referral and participation in early intervention treatment.
- **Referrals to SMI, SUD, and other MH Services:** Prevention-focused programs often make referrals to a higher level of care for SMI, SUD, and other mental health needs. As these referrals are made to different programs within an agency or to outside agencies that generally use different electronic health record systems or other data systems, collecting additional data on the duration of untreated mental illness or interval between referral and enrollment is not feasible for these referrals. Therefore, Prevention Programs that make referrals to SMI, SUD, or other mental health services will only report on the number of referrals made for each category of referrals and indicate whether those referrals were made within the PEI-program's agency, or to a County* or other outside agency.
- **Referral Data Reporting:** All programs will be asked to provide unduplicated individual-level data, from their primary program component, on any referrals made to SMI/SUD/Other MH, social services and other services. If collected, referrals made for individuals reached through other program components will also be reported. These referral data will be reported on separate tabs of the PEI data template spreadsheet. If programs do not have a process to collect individual-level data on referrals made through other (non-primary) program components, they may choose to only report aggregate totals for those referrals.

** Treatment services/programs provided, funded, administered, or overseen by the County can report sources of referrals and data related to average duration of untreated mental illness and the interval between a referral and participation in treatment. This will not be reported by the PEI Programs.*

Individual/Program Outcomes

The individual/program outcomes section of the MHSA Annual Reporting Template includes three subsections:

1. **Increased protective factors/decreased risk factors and/or increased recovery indicators/decreased symptoms:** All programs will report under this section.

- Prevention Programs will primarily report on increased protective factors/decreased risk factors, and
- Early Intervention Programs will primarily report on increased recovery indicators/decreased symptoms.

2. **Stigma reduction:** Only programs with a stigma reduction strategy will report outcomes in this subsection. Programs not included in the stigma reduction strategy category may report outcomes related to stigma reduction in the other two outcome sections.
3. **Additional program and/or individual outcomes:** All programs can report additional outcomes under this section.

To allow for BHRS to assess the impact across all its PEI-funded programs, this data collection and reporting framework uses a set of Outcome Domains under which programs can report their specific data. The subsections listed above requires that PEI programs identify a corresponding Outcome Domain for each data point. See Appendix B for a complete visual overview of the domains that will be reported on for each program and see Appendix C for a full inventory of the specific data indicators that will be reported. These Outcome Domains were identified in alignment with MHSA requirements, our local BHRS Office of Diversity and Equity's (ODE) strategic planning, and through this project's exploration of expected outcomes across the current PEI-funded programs.

The **PEI Outcome Domains** used in this framework include:

- Access to services
- Community advocacy
- Connection and support
- Cultural identity/cultural humility
- General mental health
- Improved knowledge, skills, and/or abilities
- Self-empowerment
- Stigma reduction
- Utilization of emergency services

Increased Protective Factors/Decreased Risk Factors and/or Increased Recovery Indicators/Decreased Symptoms

Key decision points:

Table 3. Primary Program Component Individual Outcomes (7A)

PEI Component	PEI Program	Access to services	Community advocacy	Connection and support	Cultural identity/ Cultural humility	General mental health	Improved knowledge, skills, and/or abilities	Self-empowerment	Stigma reduction	Utilization of emergency services	Other
Prevention	Health Ambassador Program		✓	✓				✓			
	Youth Health Ambassador Program			✓				✓			
	Mindfulness-Based Substance Abuse Treatment						✓				
	The Panche Be Youth Project	✓			✓			✓	✓		
Prevention & Early Intervention	Early Childhood Community Team			✓			✓				
	Project SUCCESS						✓	✓	✓		
	The Cariño Project					✓					

Key Decision Point

How PEI Programs will report on Increased Protective Factors/Decreased Risk Factors or Increased Recovery Indicators/Decreased Symptoms

- The outcomes that programs select for this subsection must demonstrate the impact on individuals served through the program's primary component(s). For example, if a program's primary component is short-term clinical therapy for youth, but it also offers workshops to family members through other program components, the outcomes reported under this subsection should focus on the youth receiving clinical therapy.

Key Decision Point

How PEI Programs will report on Stigma Reduction

- To better define the type of stigma reduction impact and to align this reporting framework with other program impacts, the stigma reduction outcome section is broken into three concepts of stigma reduction: (1) Self/internalized, (2) Seeking help/treatment, and (3) Public/external. Programs may choose to report on indicators aligned with any of the stigma reduction concepts. See Table 4 for each program's stigma reduction concepts.

PEI Component	PEI Program	Access to services	Community advocacy	Connection and support	Cultural identity/ Cultural humility	General mental health	Improved knowledge, skills, and/or abilities	Self-empowerment	Stigma reduction	Utilization of emergency services	Other
	Peer Counseling			✓		✓					
	Youth S.O.S.			✓			✓	✓			
Early Intervention	Primary Care Interface					✓					
	re(MIND) Early Psychosis Program					✓				✓	
	The Pride Center			✓		✓	✓				

Stigma Reduction

Table 4. Stigma Reduction Outcomes

PEI Component	PEI Program	Self/ Internalized	Seeking Help/Treatment	Public/External	Not Required to Report on Stigma Reduction
Prevention	Health Ambassador Program		✓	✓	

	Youth Health Ambassador Program	✓	✓		
	Mindfulness-Based Substance Abuse Treatment				✓
	The Panche Be Youth Project				✓
Prevention & Early Intervention	Early Childhood Community Team	✓	✓		
	Project SUCCESS				✓
	The Cariño Project	✓			
	Peer Counseling	✓	✓		
	Youth S.O.S.				✓
Early Intervention	Primary Care Interface				✓
	re(MIND) Early Psychosis Program				✓
	Pride Center				✓

Other Individual/Program Outcomes

Key Decision Point

How PEI Programs will report on Other Individual/Program Outcomes

- The outcomes that programs select for this subsection may demonstrate either additional impact of the program on individuals served through the program's primary component(s) or the impact on individuals reached through the program's other components. For example, if a program's primary component is short-term clinical therapy for youth, but it also offers workshops to family members through other program components, the program may choose to report on additional outcomes for the youth receiving clinical therapy and/or family members attending workshops.

Table 5. Additional Program/Individual Outcomes (7C)

PEI Component	PEI Program	Access to services	Community advocacy	Connection and	Cultural identity/ Cultural humility	General mental health	Improved knowledge, skills, and/or abilities	Self-empowerment	Stigma reduction	Utilization of emergency services	Other
Prevention	Health Ambassador Program	✓					✓				
	Youth Health Ambassador Program	✓	✓				✓				
	Mindfulness-Based Substance Abuse Treatment						✓				
	The Panche Be Youth Project			✓			✓				
Prevention & Early Intervention	Early Childhood Community Team	✓	✓		✓						
	Project SUCCESS					✓					
	The Cariño Project			✓	✓		✓				
	Peer Counseling	✓				✓					
	Youth S.O.S.	✓								✓	
Early Intervention	Primary Care Interface					✓	✓	✓			
	re(MIND) Early Psychosis Program							✓	✓		✓
	The Pride Center										

Appendix A: Program Crosswalks

This appendix includes the crosswalks for the following programs:

- The Cariño Project
- Early Childhood Community Team
- Health Ambassador Program
- Mindfulness-Based Substance Abuse Treatment
- The Panche Be Youth Project
- Peer Counseling
- The Pride Center
- Primary Care Interface
- Project SUCCESS
- re(MIND) Early Psychosis Program
- Youth Health Ambassador Program
- Youth S.O.S.

THE CARIÑO PROJECT

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used
Individual information and demographics	5	Unduplicated number of individuals served in primary program components (clinical)	Clinical spreadsheet
	PEI Data Template, Individual Demographics (long) tab	Demographics of unduplicated individuals served in clinical component	Demographics collected from clinical participants
	5	Duplicated number of individuals served through other program components (case management, events, workshops, groups, and outreach activities)	Attendance and outreach tracking logs, case management spreadsheet
	PEI Data Template, Individual Demographics (short) tab	Demographics of individuals reached through other program components (case management, events, workshops, groups, and outreach activities), may be duplicated *Note: You may submit additional demographic data for case management participants on this tab since you are using the long demographic form for case management.*	Demographics of duplicated attendees collected from the participant survey provided to attendees or events, groups, workshops, and any outreach activities and demographics of case management participants.
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or other MH)	SMI referrals from the Clinical spreadsheet, SMI referral log (If you start making referrals for substance use treatment, you can add a column to the referral log tab to capture whether the referral is SMI or SUD.) Also non-SMI mental health referrals to organizations outside ALAS will be captured in the Case Management spreadsheet, Mental health referral tracking tab and noted as Other in Column F.
		Programs or treatment referred to	

	PEI Data Template, Referrals Out tab	Individual-level data on mental health and substance use referrals to other agencies and within ALAS		Same as above
Referrals to other services	6C	Number of referrals to other services by type		Case management spreadsheet, social referral tracking tab
	PEI Data, Referrals Out tab	Individual-level data on referrals to other services		Same as above
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: General mental health	Number who experience an overall improvement in their mental health (clinical population)	#/% of clinical participants who improved rating for question #1 from intake clinical self-assessment to ongoing/discharge clinical self-assessment (taken every 6 months)
		Domain: General mental health	Number who reported an improved ability to manage mental health symptoms (clinical population)	#/% of clinical participants who improved rating for question #2 from intake clinical self-assessment to ongoing/discharge clinical self-assessment
		Domain: General mental health	Number who reported an improved ability to cope with stressors (clinical population)	#/% of clinical participants who improved rating for question #3 from intake clinical self-assessment to ongoing/discharge clinical self-assessment
		Domain: General mental health	Number who reported that the services they are receiving are helping them to do better in daily life (clinical population)	#/% of clinical participants who improved rating for question #7 from intake clinical self-assessment to ongoing/discharge clinical self-assessment
Individual Outcomes – Stigma Reduction	7B	Stigma (Self/Internalized)	Number of participants who reported feeling more comfortable talking about mental health since they began attending sessions (clinical population)	#/% of participants who selected somewhat agree or agree on question #8 on the ongoing/discharge clinical self-assessment (use the latest assessment per individual)

Additional Individual/Program Outcomes	7C	Domain: Cultural identity	Number who felt more connected to their culture (participant population)	#/% of event/workshop participant survey respondents who selected somewhat agree or agree on question #4.
		Domain: Connection and Support	Number who reported being better able to support themselves and/or their family after receiving services (case management population)	#/% of case management survey respondents who selected somewhat agree or agree on question #8.
		Domain: Improved knowledge, skills, and/or abilities	Number who learned something new that was useful to them (participant population)	#/% of event/workshop participant survey respondents who selected somewhat agree or agree on question #6.

EARLY CHILDHOOD COMMUNITY TEAM

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program components (children who are receiving one-on-one services, including direct therapy, and participating in groups)		ETO
	PEI Data Template	Demographics of unduplicated individuals served in primary program components (children who are receiving one-on-one services, including direct therapy, and participating in groups)		ETO
	5	Number of individuals reached in all other program components (parents and caregivers in groups, teachers who receive consultations, children reached by consultations), may be duplicated		ETO
	PEI Data Template	Demographics of individuals reached in all other program components, (parents and caregivers in groups, teachers who receive consultations, children reached by consultations), may be duplicated		ETO
Referrals to your PEI program	6A	Number of referrals into ECCT		ETO
		Number of referrals that resulted in enrollment (number engaged)		ETO
	PEI Data Template	Individual-level data on referrals into ECCT		ETO
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or other MH) *Note: SMI referrals should include referrals to any services for beyond mild to moderate needs.*		ETO
		Programs or treatment referred to		ETO
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within your agency		ETO
Referrals to other services	6C	Number of referrals by type		ETO
	PEI Data Template	Individual-level data on referrals to other services		ETO
Individual Outcomes – Increased Protective	7A	Domain: Improved knowledge, skills, and/or abilities	Number of parents/caregivers who improved their parenting knowledge, skills, and abilities as measured by an improvement in	Parent Stress Index, ETO

Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms			their Parent Stress Index score (population = one-on-one services)	
		Domain: Connection and support	Number of parents/caregivers who improved their familial connection and support as measured by an improvement in their Protective Factors Survey score (population = one-on-one services)	Protective Factors Survey, ETO
		Domain: Improved knowledge, skills, and/or abilities	Due to my engagement in this program, I feel more confident in my parenting. (population = group services)	End of year/group survey, ETO
		Domain: Connection and support	Due to my engagement in this program, I feel more connected to other parents in my community. (population = group services)	End of year/group survey, ETO
Individual Outcomes – Stigma Reduction	7B	Stigma (Self/Internalized)	Number who experience changes in attitudes, knowledge, or behavior related to mental illness – I feel more comfortable talking about my and my child's mental health/children in my classroom. (population = group, teacher consultations, and one-on-one services)	End of year/group survey, ETO
		Stigma (Seeking Help/Treatment)	Number who experience changes in attitudes, knowledge, or behavior related to seeking mental health services. – I felt more comfortable seeking out resources for my child. (population = group, teacher consultations, and one-on-one services)	End of Year/Group Survey
Additional Individual/Program Outcomes	7C	Domain: Access to services	Due to my engagement, I know where to go in my community for resources and support. (population	End of Year/Group Survey

			= groups, teacher consultations, and one-on-one services)	
		Domain: Community advocacy	Due to my engagement, I feel more empowered to advocate for myself and my child's needs. (population = group and one-on-one services)	End of Year/Group Survey
		Domain: Cultural identity/humility	I feel like my identity is affirmed by this program. (population = groups, teacher consultations, one-on-one services)	End of Year/Group Survey

HEALTH AMBASSADOR PROGRAM

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Participant (individual) information and demographics	5	Number of unduplicated individuals served in primary program component (ambassadors)		Existing intake log
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (long form on ambassador intake)		Existing intake log
	5	Number of individuals reached in all other program components (those impacted by community outreach/presentations), may be duplicated		Existing intake log
	PEI Data Template	Demographics of individuals reached in all other program components, (those impacted by community outreach/presentations) may be duplicated (short)		Existing intake log
	PEI Data Template	Individual-level data on SDOH responses		Referral/SDOH tracking log
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or MH) *Note: You can report on referrals provided to both ambassadors and audience members.*		Referral/SDOH tracking log
		Programs or treatment referred to		Referral/SDOH tracking log
	PEI Data Template	Individual-level data on mental health and substance use referrals *Note: Please provide a individual ID with referrals made for ambassadors. You do not need to report a individual ID for referrals made for audience members.*		Referral/SDOH tracking log
Referrals to other services	6C	Number of referrals by type *Note: You can report on referrals provided to both ambassadors and audience members.*		Referral/SDOH tracking log
	PEI Data Template	Individual-level data on referrals to other services *Note: Please provide a individual ID with referrals made for ambassadors. You do not need to report a individual ID for referrals made for audience members.*		Referral/SDOH tracking log
Individual/Participant Outcomes – Increased	7A	Domain: Connection and support	Due to my participation in HAP courses and/or activities, I feel more connected to my family. (population = HAP ambassadors)	HAP Ambassador Annual Survey

Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms		Domain: Community advocacy	Due to my participation in HAP courses and/or activities, I am more confident in my ability to create change in my community. (population = HAP ambassadors)	HAP Ambassador Annual Survey
		Domain: Self-empowerment	Due to my participation in HAP courses and/or activities, I am more confident in my ability to advocate for myself and/or advocate for my child/children. (population = HAP ambassadors)	HAP Ambassador Annual Survey
Individual Outcomes – Stigma Reduction	7B	Stigma (Seeking Help/Treatment)	Due to my participation in this course, I feel more comfortable seeking mental health services for myself and/or my family. (population = course audience members including both community members and ambassadors, may be duplicated)	HAP course survey addendum (collected from each HAP course)
		Stigma (Public/External)	My participation in this course has helped improve my understanding of how stigma impacts people living with mental health problems and/or substance abuse. (population = course audience members including both community members and ambassadors, may be duplicated)	HAP course survey addendum (collected from each HAP course)
Additional Individual/Program Outcomes	7C	Domain: Improved knowledge, skills, and/or abilities	Through my participation in this course, I've learned behavioral health knowledge and skills that I can use in my personal and/or family life. (population = course audience members including both community members and ambassadors, may be duplicated)	HAP course survey addendum (collected from each HAP course)
		Domain: Improved knowledge, skills, and/or abilities	Through my participation in this course, I've learned behavioral health knowledge and skills that I can use in my community. (population = course audience members including both community members and ambassadors, may be duplicated)	HAP course survey addendum (collected from each HAP course)
		Domain: Access to services	Through my participation in this course, I and/or my family have been connected to mental health services/resources that have been helpful. (population = course audience members including	HAP course survey addendum (collected from

			both community members and ambassadors, may be duplicated)	each HAP course)

MINDFULNESS-BASED SUBSTANCE ABUSE TREATMENT

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used ***Note: Each MBSAT agency can complete the sources based on its processes.***
Participant (individual) information and demographics	5	Number of unduplicated individuals served in primary program component (youth cohort)	
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (youth cohort) (long)	
	5	Number of individuals reached in all other program components (those impacted by community outreach/presentations, family members of youth, providers), may be duplicated	
	PEI Data Template	Demographics of individuals reached in all other program components (those impacted by community outreach/presentations, family members of youth, providers), may be duplicated (short)	
	PEI Data Template	Individual-level data on social determinants of health screener responses	
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or MH) *Note: You can report on referrals provided to both youth cohort members and family members.*	
		Programs or treatment referred to	
	PEI Data Template	Individual-level data on mental health and substance use referrals *Note: Please provide a individual ID with referrals made for youth cohort members. You do not need to report a individual ID for referrals made for family members.*	
Referrals to other services	6C	Number of referrals by type *Note: You can report on referrals provided to both youth cohort members and family members.*	

	PEI Data Template	Individual-level data on referrals to other services *Note: Please provide a individual ID with referrals made for cohort members. You do not need to report a individual ID for referrals made for family members.*		
Individual/Participant Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Improved knowledge, skills, and/or abilities	Because I participated in this program, when I'm worried about something, I make myself think about it in a way that helps me feel better. (population = youth cohort)	Revised ERQ (post program only)
		Domain: Improved knowledge, skills, and/or abilities	Because I participated in this program, I control my feelings about things by changing the way I think about them. (population = youth cohort)	Revised ERQ (post program only)
		Domain: Improved knowledge, skills, and/or abilities	When I want to feel better about something, I change the way I'm thinking about it. (population = youth cohort)	Revised ERQ (post program only)
Additional Individual/Program Outcomes	7C	Domain: Improved knowledge, skills, and/or abilities	As a result of participating in this program, I learned that trauma affects physical, emotional, and mental well-being. (population = Trauma 101 attendees/family members/providers)	Trauma 101 post survey
		Domain: Improved knowledge, skills, and/or abilities	As a result of participating in this program, I believe that recovery from trauma is possible. (population = Trauma 101 attendees/family members/providers)	Trauma 101 post survey
		Domain: Improved knowledge, skills, and/or abilities	Due to my participation in this program, I practice self-care (taking care of my own needs and well-being). (population = Trauma 101 attendees/family members/providers)	Trauma 101 post survey
		Domain:	As a result of participating in this program, I believe in and support the principles of Trauma Informed Practice	Trauma 101 post survey

		Improved knowledge, skills, and/or abilities	(TIP). (population = Trauma 101 attendees – providers only)	

THE PANCHE BE YOUTH PROJECT

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program component (youth)		Intake Form
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (youth)		Intake Form
	PEI Data Template	Individual-level data on social determinants of health screener responses		Intake form
	5	Number of individuals reached in other program components (family members), may be duplicated		Parent orientation forms
	PEI Data Template	Demographics of individuals reached in other program components (family members), may be duplicated		Parent orientation forms
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or other MH)		Program Data
		Programs or treatment referred to		Program Data
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within your agency		Program Data
Referrals to other services	6C	Number of referrals by type		Program Data
	PEI Data Template	Individual-level data on referrals to other services		Program Data
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Self-empowerment	I have "control" of my own narrative, design my own narrative, go for my dreams. (population = youth)	Youth Pre/Post Survey
		Domain: Stigma reduction (Self/Internal)	I feel more comfortable speaking about mental health challenges. (population = youth)	Youth Pre/Post Survey
		Domain: Access to services	I know at least one place I can go for mental health services. (population = youth)	Youth Pre/Post Survey

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
		Domain: Cultural identity/humility	I feel proud and connected to my cultural roots. (population = youth)	Youth Pre/Post Survey
		Domain: Cultural identity/humility	I can name three positive values from my culture. (population = youth)	Youth Pre/Post Survey
Additional Individual/Program Outcomes	7C	Domain: Improved knowledge, skills, and abilities	Parent perception of improved behavior/academics of daughter (population = family members)	Panche Be Parent Survey
		Domain: Connection and support	Improved relationship between parent/sibling and daughter (population = family members)	Panche Be Parent Survey

PEER COUNSELING

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Individual/Participant information and demographics	5	Number of unduplicated individuals served in primary program components (one-on-one peer counseling and group sessions)		ETO
	PEI data template	Demographics of unduplicated individuals served in primary program components (one-on-one peer counseling and group sessions) *Note: Please provide an explanation in section 5 of the annual report template stating the reason why Peer Counseling is not reporting SOGI data for its unduplicated individuals served.*		ETO
Referrals to your PEI program	6A	Number of referrals to Peer Counseling		ETO
		Number of referrals that resulted in enrollment (number engaged)		ETO
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals and types of treatment referred to (SMI, SUD, or other MH)		ETO
		Programs or treatment referred to		ETO
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within agency		ETO
Referrals to other services	6C	Number of referrals by type		ETO
	PEI Data Template	Individual-level data on referrals to other services		ETO
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: General mental health	As a result of participating in this program, I feel less stressed.	Participant survey
		Domain: Connection and support	As a result of participating in this program, I feel supported.	Participant survey
Stigma Reduction	7B	Stigma (Self/Internalized)	Due to this program, I feel more comfortable talking about my problems.	Participant survey

		Stigma (Seeking Help/Treatment)	Due to this program, I feel more comfortable reaching out for emotional support.	Participant survey
Additional Individual/Program Outcomes	7C	Domain: Improved knowledge, skills, and/or abilities	The program improved my knowledge and abilities to seek support.	Participant survey
		Domain: Access to services	As a result of participating in this program, I am connected to community resources.	Participant survey

THE PRIDE CENTER

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program component (therapy and case management)	ETO
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (therapy and case management)	ETO / Participant Information Form
	5	Number of individuals reached in all other program components (peer groups, trainings, consultations), may be duplicated	ETO / Spreadsheet (for now)
	PEI Data Template	Demographics of individuals reached in all other program components (peer groups, trainings, consultations), may be duplicated	ETO / Participant Information Form
Referrals to your PEI program	6A	Number of referrals to PEI program *Note: Referral counts should be unduplicated for the "primary program component" - case management or therapy services, but not duplicated even if someone was referred to both. If a family is referred, count each individual separately.*	ETO
		Number of referrals that resulted in enrollment (number engaged)	ETO
		Duration of untreated mental illness *Maybe appropriate for screening or assessment questions.*	ETO
		Average interval between referral and enrollment	ETO
		Minimum length of time from referral to enrollment	ETO
		Maximum length of time from referral to enrollment	ETO
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals and types of treatment referred to (SMI, SUD, or MH) to other agencies and within StarVista	Spreadsheet (for now)
		Programs or treatment referred to	Spreadsheet (for now)
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within StarVista	

Referrals to other services	6C	Number of referrals by type		Spreadsheet (for now)
	PEI Data Template	Individual-level data on referrals to other services		
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: General mental health	Number of individuals who experienced reduced depression symptoms as measured by a reduction in their ANSA/CANS depression subscale score. (population = youth and adult therapy services)	CANS/ANSA
		Domain: General mental health	Number of individuals who experienced reduced anxiety symptoms as measured by a reduction in their ANSA/CANS anxiety subscale score. (population = youth and adult therapy services)	CANS/ANSA
		Domain: Improved knowledge, skills, and/or abilities	Number of individuals who experienced improved social and relationship skills as measured by a reduction in their CANS Interpersonal subscale score (population = youth therapy services) and by a reduction in their ANSA Interpersonal/social connectedness subscale score (population = adult therapy services).	CANS/ANSA
		Domain: Connection and Support	Number of individuals who experienced improved support as measured by a reduction in their CANS Natural Supports subscale score (population = youth therapy services) and by a reduction in their ANSA Community Connection subscale score. (population = adult therapy services)	CANS/ANSA
Additional Individual/Program Outcomes	7C	Domain: General Mental Health	Number of individuals who reported an improvement in their mental health as measured by the following: "How would you rate your mental health in the last 30 days?" (population = therapy services)	Mental Health Self-Assessment
		Domain: General Mental Health	Number of individuals who reported an improvement in their ability to cope with	Mental Health Self-Assessment

			stress as measured by the following: "How would you rate your ability to cope with stress in the last 30 days?" (population = therapy services)	
		Domain: Self-empowerment	Number of individuals who reported improved self-empowerment as measured by the following: "I am confident I can affect my life through the decisions I make?" (population = therapy services)	Mental Health Assessment
		Domain: Stigma Reduction	Number of individuals who reported reduced self-stigma as measured by the following: "I feel comfortable talking about my sexual orientation and/or gender identity?" (population = therapy services)	Mental Health Assessment
		Domain: Improved knowledge, skills, and/or abilities	Number of individuals who reported improved knowledge as measured by the following: "After this training, I now have a strong understanding of issues impacting the LGBTQ+ community." (population = individuals reached in other program components)	Individual survey
		Domain: Connection and support	Number of individuals who reported feeling more connected as measured by the following: "I feel more socially connected by participating in Pride Center programs and services." (population = individuals reached in other program components)	Individual survey

PRIMARY CARE INTERFACE

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program component (counseling, case management, psychiatry – number who received services)	"Interface Episode by referral source" report in Avatar
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (counseling, case management, psychiatry – number who received services)	Avatar report
Referrals to your PEI program	6A	Number of referrals to Primary Care Interface	"Interface Episode by referral source" report in Avatar
		Number of referrals that resulted in enrollment (number engaged – defined as having completed intake)	
		Average duration of untreated mental illness (*if available - time between the self-reported onset of symptoms that brought them into treatment this time and entry into treatment(intake)*)	
		Average interval between referral date and enrollment date (date assessment received)	
		Minimum length of time from referral to enrollment	
		Maximum length of time from referral to enrollment	
	PEI Data Template	Individual-level data on referrals into Primacy Care Interface	AVATAR
Mental health and substance use referrals to other agencies **and** within your agency	6B	Number of referrals by type of treatment referred to Region, SUD, or other MH within BHRS (Pre-to-3, TAY, AOD IMAT)	
		Programs or treatment referred to outside agencies (AOD In/out pt; PPN, CORA, KARA, School)	

	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies (from PCI, in disposition?) and within your agency (BHRS)		AVATAR
Referrals to other services (Other than SUD or MH)	6C	Number of referrals by type (Housing, food, Social worker, Job, etc.)		
	PEI Data Template	Individual-level data on referrals to other services		AVATAR
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: General Mental Health	Number who experience reduced anxiety symptoms (as measured by a change in their GAD-7 overall score)	AVATAR GAD-7 Scale
		Domain: General Mental Health	Number who experience reduced depressive symptoms (as measured by a change in their PHQ-9 overall score)	AVATAR PHQ-9 Scale
Additional Individual/Program Outcomes	7C	Domain: General mental health	As a result of participating in this program, I am better able to manage my symptoms and participate in daily life.	
		Domain: Self-empowerment	As a result of participating in this program, I think more positively about challenges and I believe the decisions and steps I take impact my outcome.	
		Domain: Improved knowledge, skills, and/or abilities	As a result of participation in this program, I learned skills and strategies to cope with stressors.	

PROJECT SUCCESS

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served through primary program component (group services and one-on-one counseling)		TheraNest platform; Excel spreadsheet
	PEI Data Template	Demographics of unduplicated individuals served through primary program component (group services and one-on-one counseling)		TheraNest platform; Excel spreadsheet
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or other MH)		TheraNest platform; Excel spreadsheet
		Programs or treatment referred to		TheraNest platform; Excel spreadsheet
	PEI Data Template	Individual-level data on mental health and substance use referrals		TheraNest platform; Excel spreadsheet
Referrals to other services	6C	Number of referrals by type		TheraNest platform; Excel spreadsheet
	PEI Data Template	Individual-level data on referrals to other services		TheraNest platform; Excel spreadsheet
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Stigma reduction (Self/Internalized)	Due to this program, I feel more comfortable talking about my challenges with using alcohol and/or drugs. (population = groups)	Group post survey
		Domain: Self-empowerment	Puente's Project Success helped me understand how to better manage how I respond to my thoughts and feelings. (population = groups)	Group post survey

		Domain: Improved knowledge, skills, and/or abilities	Due to this program, I learned skills that help me to express my emotions and opinions more effectively. (population = groups)	Group post survey
Additional Individual/Program Outcomes	7C	Domain: General mental health	Decrease in depressive symptoms for one-to-one counseling participants (as measured by change in their overall PHQ-9 score)	PHQ-9 – [indicate the collection/ reporting approach used (e.g., collecting every 6 months or once a year in the summer)]
		Domain: General mental health	Decrease in anxiety symptoms for one-to-one counseling participants (as measured by change in their overall GAD-7 score)	GAD-7 - [indicate the collection/ reporting approach used (e.g., collecting every 6 months or once a year in the summer)]

RE(MIND) EARLY PSYCHOSIS PROGRAM

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program components (early psychosis treatment and re(MIND) Alumni *(only count BEAM aftercare)*)		EHR
	PEI Data Template	Demographics of unduplicated individuals served in primary program components (early psychosis treatment and BEAM aftercare)		EHR
	5	Number of individuals served in other program components (family members/caregivers), may be duplicated		EHR
Referrals to your PEI program	6A	Number referrals to re(MIND)		EHR
		Number engaged/enrolled in re(MIND)		EHR
		Average duration of untreated psychosis		EHR
		Average interval between referral and enrollment		EHR
		Minimum length of time from referral to enrollment		EHR
		Maximum length of time from referral to enrollment		EHR
	PEI Data Template	Individual-level data on referrals to re(MIND)		EHR
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or other MH)		EHR
		Programs or treatment referred to		EHR
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within your agency (internal transfers to BEAM)		EHR
Referrals to other services	6C	Number of referrals by type		EHR
	PEI Data Template	Individual-level data on referrals to other services		EHR
Individual Outcomes – Increased Protective Factors/Improved Recovery	7A	Domain: Utilization of emergency/crisis services	Reduction in hospitalizations (both number of days and number of episodes) for participants and alumni	EHR
		Domain: General mental health	Improvement engagement in meaningful activities	EHR

Indicators; Decreased Risk Factors/Symptoms			(employment, academic placement/progression, volunteerism) for participants and alumni	
		Domain: General mental health	CANS – psychosis (improvement in score by at least one point or maintenance in score of 1 from initial to followup for participants and alumni	EHR
Additional Individual/Program Outcomes	7C	Domain: Stigma (Self/Internalized)	"Due to this program, I am able to understand myself better." Disagree Strongly; Disagree; Neither Agree/Disagree; Agree; Agree Strongly for participants and alumni	Program-administered survey
		Domain: Stigma (Externalized)	"I think that people with mental health challenges can lead healthy lives." Disagree Strongly; Disagree; Neither Agree/Disagree; Agree; Agree Strongly for participants and alumni	Program-administered survey
		Domain: Self-empowerment	"Due to this program, I can take control of aspects of my life" Disagree Strongly; Disagree; Neither Agree/Disagree; Agree; Agree Strongly for participants and alumni	Program-administered survey
		Domain: Other - Contracted Satisfaction	"I am satisfied with the services I have received at (re)MIND/BEAM program" Disagree Strongly; Disagree; Neither Agree/Disagree; Agree; Agree Strongly for participants and alumni	Program-administered survey

YOUTH HEALTH AMBASSADOR PROGRAM

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured		Data collection tool used
Participant (individual) information and demographics	5	Number of unduplicated individuals served in primary program component (cohort)		Demographics Survey - Cohort
	PEI Data Template	Demographics of unduplicated individuals served in primary program component (long)		Demographics Survey- Cohort
	5	Number of individuals reached in all other program components (those impacted by community outreach/presentations), may be duplicated		Audience survey
	PEI Data Template	Demographics of individuals reached in all other program components, may be duplicated (short)		Audience survey
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals by type of treatment referred to (SMI, SUD, or MH) *Note: You can report on referrals provided to both cohort members and audience members.*		Survey, Excel Document
		Programs or treatment referred to		Excel Document
	PEI Data Template	Individual-level data on mental health and substance use referrals *Note: Please provide a individual ID with referrals made for cohort members. You do not need to report a individual ID for referrals made for audience members.*		Excel Document
Referrals to other services	6C	Number of referrals by type *Note: You can report on referrals provided to both cohort members and audience members.*		Excel Document
	PEI Data Template	Individual-level data on referrals to other services *Note: Please provide a individual ID with referrals made for cohort members. You do not need to report a individual ID for referrals made for audience members.*		Excel Document
Individual/Participant Outcomes – Increased Protective Factors/Improved	7A	Domain: Connection and support	I feel that I am part of a community. (population = cohort)	Cohort Exit-Survey
		Domain: Self-empowerment	I have a positive attitude about myself. (population = cohort)	Cohort Exit-Survey

Recovery Indicators; Decreased Risk Factors/Symptoms		Domain: Self-empowerment	Due to my participation in HAP-Y, I am interested in pursuing a career in mental health. (population = cohort)	Cohort Exit-Survey
Individual Outcomes – Stigma Reduction	7B	Stigma (Self/Internalized)	I feel comfortable discussing topics related to mental health. (population = cohort and audience)	Exit-Survey and Audience Survey
		Stigma (Seeking Help/Treatment)	I feel comfortable seeking mental health services. (population = cohort and audience)	Exit-Survey and Audience Survey
Additional Individual/Program Outcomes	7C	Domain: Community advocacy	Due to this program, I am more confident in my ability to create change in my community. (population = cohort)	Cohort Exit Survey
		Domain: Access to services	I know who to call or access online if I need mental health services. (population = audience)	Audience Survey
		Domain: Improved knowledge, skills, and/or abilities	HAP-Y provided me with knowledge and skills that I continued to use. (population = cohort)	Cohort Exit-Survey

YOUTH S.O.S.

Reporting Requirement	Annual Report Section	Key outputs and/or outcomes measured	Data collection tool used
Individual information and demographics	5	Number of unduplicated individuals served in primary program component (mobile crisis response)	
	PEI data template	Demographics of unduplicated individuals served in primary program component (mobile crisis response)	
	5	Number of individuals served through other program components (family members or caregivers of youth served, individuals reached through outreach/education), may be duplicated	
	PEI data template	Demographics of individuals served through other program components (family members or caregivers of youth served, individuals reached through outreach/education), may be duplicated	
Referrals to your PEI program	6A	Number of referrals to Youth S.O.S. (crisis calls)	
		Number of referrals that resulted in enrollment/number engaged (Youth S.O.S. goes out)	
Mental health and substance use referrals to other agencies and within your agency	6B	Number of referrals and types of treatment referred to (SMI, SUD, or other MH) *Note: Please report on referrals provided to youth here. Additional referrals made for family members/caregivers or outreach/education recipients can be included in the individual-level data.*	
		Programs or treatment referred to	
	PEI Data Template	Individual-level data on mental health and substance use referrals to other agencies and within your agency *Note: Please provide a individual ID with referrals made for youth. You do not need to report a individual ID for additional referrals made for family members/caregivers or outreach/education recipients.*	
Referrals to other services	6C	Number of referrals by type *Note: Please report on referrals provided to youth here. Additional referrals made for family members/caregivers or outreach/education recipients can be included in the individual-level data.*	
	PEI Data Template	Individual-level data on referrals to other services	

		Note: Please provide a individual ID with referrals made for youth. You do not need to report a individual ID for additional referrals made for family members/caregivers or outreach/education recipients.		
Individual Outcomes – Increased Protective Factors/Improved Recovery Indicators; Decreased Risk Factors/Symptoms	7A	Domain: Improved knowledge, skills, and/or ability	Number of youth who learned a new coping strategy to increase mental, emotional, and relational functioning. (population = youth who received Youth S.O.S. services)	Intake form-Intervention section
		Domain: Connection and Support	Number of youths who can identify and feel safe reaching out and contacting at least one adult when they are experiencing emotional distress during a follow up session.	Follow-up rating form
		Domain: Self-empowerment	Number of youth who can identify and feel confident accessing emergency mental health services when their emotional distress is high. (population = youth who received Youth S.O.S. services)	Follow-up rating form
Additional Individual/Program Outcomes	7C	Domain: Utilization of emergency services	Youth diverted from use of psychiatric emergency services (population = youth who received Youth S.O.S. services)	
		Domain: Utilization of emergency services	Youth will not require law enforcement intervention (population = youth who received Youth S.O.S. services)	
		Domain: Access to services	Number of caregivers or family members who received psychoeducation and resources to increase youth's community and relational support. (population = family members/caregivers of youth)	

Appendix B: Outcome Domain Summary

Table 6 includes all outcome domains reported on by each program. Blue check marks represent outcomes for the program's primary components and orange check marks represent outcomes for the program's other components. Outcomes for primary program components will be reported under sections 7A or 7C. Outcomes for other program components will be reported under sections 7B or 7C.

Table 6. PEI Program and Individual Outcome Summary

PEI Component	PEI Program	Access to services	Community	Connection and	Cultural identity/ Cultural humility	General mental	Improved knowledge, skills,	Self-empowerment	Stigma reduction (Self/internalized)	Stigma reduction (Seeking help)	Stigma reduction (Public/external)	Utilization of emergency	Other
Prevention	Health Ambassador Program	✓	✓	✓			✓	✓	✓	✓			
	Youth Health Ambassador Program	✓	✓	✓			✓	✓	✓ ✓	✓ ✓			
	MBSAT						✓ ✓						
	The Panche Be Youth Project	✓		✓	✓		✓	✓	✓				
Prevention & Early Intervention	Early Childhood Community Team	✓ ✓	✓ ✓	✓	✓ ✓		✓		✓ ✓	✓ ✓			
	Project SUCCESS					✓	✓	✓	✓				
	The Cariño Project			✓	✓	✓	✓		✓				
	Peer Counseling	✓		✓		✓	✓		✓	✓			
	Youth S.O.S.	✓		✓			✓	✓				✓	
Early Intervention	Primary Care Interface					✓	✓	✓					
	re(MIND)					✓		✓	✓		✓	✓	✓
	The Pride Center			✓ ✓		✓	✓ ✓	✓	✓				

Appendix C: Outcome Indicators

Table 7 provides an inventory of all indicators reported by PEI programs, by Outcome Domain.

Table 7. PEI Outcome Domains and Indicators

Outcome Domains	Sample outcome questions/statements	Program using indicator
Access to services	Due to my engagement, I know where to go in my community for resources and support.	ECCT
	As a result of participating in this program, I am connected to community resources.	Peer Counseling
	I know who to call or access online if I need mental health services.	Y-HAP
	Number of caregivers or family members who received psychoeducation and resources to increase youth's community and relational support.	Youth S.O.S.
	I know at least one place I can go for mental health services.	Panche Be Youth
	Through my participation in this course, I and/or my family have been connected to mental health services/resources that have been helpful.	HAP
Community advocacy	Due to my engagement, I feel more empowered to advocate for myself and my child's needs.	ECCT
	Due to this program, I am more confident in my ability to create change in my community.	Y-HAP
	Due to my participation in HAP courses and/or activities, I am more confident in my ability to create change in my community.	HAP
Connection and support	Due to this program, I am better able to support myself and/or my family.	Cariño Project
	Improved relationship between parent/sibling and daughter	Panche Be Youth
	Number of parents/caregivers who improved their familial connection and support as measured by an improvement in their Protective Factors Survey score	ECCT
	Due to my engagement in this program, I feel more connected to other parents in my community.	ECCT
	As a result of participating in this program, I feel supported.	Peer Counseling
	I feel that I am part of a community.	Y-HAP

	Number of youth who can identify and feel safe reaching out and contacting at least one adult when they are experiencing emotional distress during a follow up session.	Youth S.O.S.
	Number of individuals who experienced improved support as measured by a reduction in their CANS Natural Supports subscale score for youth and by a reduction in their ANSA Community Connection subscale score for adults.	Pride Center
	I feel more socially connected by participating in Pride Center programs and services.	Pride Center
	Due to my participation in HAP courses and/or activities, I feel more connected to my family.	HAP
Cultural identity/ cultural humility	Due to participating in this program, I feel more connected to my culture.	Cariño Project
	I feel like my identity is affirmed by this program.	ECCT
	I feel proud and connected to my cultural roots.	Panche Be Youth
	I can name three positive values from my culture.	Panche Be Youth
General mental health	As a result of participating in this program, I feel less stressed.	Peer Counseling
	Decrease in depressive symptoms for one-to-one counseling participants (as measured by change in their overall PHQ-9 score)	Project SUCCESS, Primary Care Interface
	Decrease in depression symptoms as measured by a reduction in their ANSA/CANS depression subscale score	Pride Center
	Decrease in anxiety symptoms for one-to-one counseling participants (as measured by change in their overall GAD-7 score)	Project SUCCESS, Primary Care Interface
	Decreased in anxiety symptoms as measured by a reduction in their ANSA/CANS anxiety subscale score	Pride Center
	Improvement engagement in meaningful activities (employment, academic placement/progression, volunteerism)	re(MIND)
	CANS – psychosis (improvement in score by at least one point or maintenance in score of 1 from initial to followup	re(MIND)
	Number who experience an overall improvement in their mental health	Cariño Project, Pride Center
	Number who reported an improved ability to manage mental health symptoms	Cariño Project, Primary Care Interface

	Number who reported an improved ability to cope with stressors	Cariño Project, Pride Center
	Number who reported that the services they are receiving are helping them to do better in daily life	Cariño Project
Improved knowledge, skills, and/or abilities	Due to this program, I learned something that is useful to me.	Cariño Project
	Parent perception of improved behavior/academics of daughter	Panche Be Youth
	Number of parents/caregivers who improved their parenting knowledge, skills, and abilities as measured by an improvement in their Parent Stress Index score.	ECCT
	Due to my engagement in this program, I feel more confident in my parenting.	ECCT
	The program improved my knowledge and abilities to seek support.	Peer Counseling
	Due to this program, I learned skills that help me to express my emotions and opinions more effectively.	Project SUCCESS
	HAP-Y provided me with knowledge and skills that I continued to use.	Y-HAP
	Number of youth who learned a new coping strategy to increase mental, emotional, and relational functioning.	Youth S.O.S.
	Number of individuals who experienced improved social and relationship skills as measured by a reduction in their CANS Interpersonal subscale score for youth and by a reduction in their ANSA Interpersonal/social connectedness subscale score for adults	Pride Center
	After this training, I now have a strong understanding of issues impacting the LGBTQ+ community.	Pride Center
	Because I participated in this program, when I'm worried about something, I make myself think about it in a way that helps me feel better.	MBSAT
	Because I participated in this program, I control my feelings about things by changing the way I think about them.	MBSAT
	When I want to feel better about something, I change the way I'm thinking about it.	MBSAT
	As a result of participating in this program, I learned that trauma affects physical, emotional, and mental well-being.	MBSAT
	As a result of participating in this program, I believe that recovery from trauma is possible.	MBSAT

	Due to my participation in this program, I practice self-care (taking care of my own needs and well-being).	MBSAT
	As a result of participating in this program, I believe in and support the principles of Trauma Informed Practice (TIP).	MBSAT
	Through my participation in this course, I've learned behavioral health knowledge and skills that I can use in my personal and/or family life.	HAP
	Through my participation in this course, I've learned behavioral health knowledge and skills that I can use in my community.	HAP
	As a result of participation in this program, I learned skills and strategies to cope with stressors.	Primary Care Interface
Self-empowerment	I am confident that I can affect my life through decisions that I make.	Pride Center
	I have "control" of my own narrative, design my own narrative, go for my dreams.	Panche Be Youth
	Puente's Project Success helped me understand how to better manage how I respond to my thoughts and feelings.	Project SUCCESS
	Due to this program, I can take control of aspects of my life.	re(MIND)
	I have a positive attitude about myself.	Y-HAP
	Due to my participation in HAP-Y, I am interested in pursuing a career in mental health.	Y-HAP
	Number of youth who can identify and feel confident accessing emergency mental health services when their emotional distress is high.	Youth S.O.S.
	Due to my participation in HAP courses and/or activities, I am more confident in my ability to advocate for myself and/or advocate for my child/children.	HAP
	As a result of participating in this program, I think more positively about challenges and I believe the decisions and steps I take impact my outcome.	Primary Care Interface
Stigma reduction (self/internalized)	Due to this program, I feel more comfortable talking about mental health since I began attending sessions.	Cariño Project
	I feel more comfortable talking about my and my child's mental health/children in my classroom.	ECCT
	Due to this program, I feel more comfortable talking about my challenges with using alcohol and/or drugs.	Project SUCCESS
	Due to this program, I am able to understand myself better.	re(MIND)

	I feel more comfortable speaking about mental health challenges.	Panche Be Youth
	Due to this program, I feel more comfortable talking about my problems.	Peer Counseling
	I feel comfortable discussing topics related to mental health.	Y-HAP
	I feel comfortable talking about my sexual orientation and/or gender identity.	Pride Center
Stigma reduction (seeking help/ treatment)	I felt more comfortable seeking out resources for my child.	ECCT
	I feel comfortable seeking mental health services.	Y-HAP
	Due to this program, I feel more comfortable reaching out for emotional support.	Peer Counseling
	Due to my participation in this course, I feel more comfortable seeking mental health services for myself and/or my family.	HAP
Stigma reduction (public/external)	I think people with mental health challenges can lead healthy lives.	re(MIND)
	My participation in this course has helped improve my understanding of how stigma impacts people living with mental health problems and/or substance abuse.	HAP
Utilization of emergency services	Reduction in hospitalizations (both number of days and number of episodes)	re(MIND)
	Youth diverted from use of psychiatric emergency services	Youth S.O.S.
	Youth will not require law enforcement intervention	Youth S.O.S.
Other	Contracted satisfaction: I am satisfied with the services I have received at (re)MIND/BEAM.	re(MIND)

APPENDIX 8. FSP EVALUATION REPORT, FY 2021-22

Full-Service Partnership Outcomes

Findings From 2021 to 2022 Fiscal Year

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San Mateo County Behavioral Health and Recovery Services

December 2022

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Executive Summary

Full-service partnerships (FSPs) are a set of enhanced, integrated services administered through San Mateo County–contracted providers to assist individuals with mental and behavioral health challenges. The American Institutes for Research® (AIR®) is working with San Mateo County (the County) to understand how enrollment in FSPs promotes resilience and improves the health outcomes of individuals served. Two data sources are used for this report: (1) self-reported survey data collected by providers from FSP clients (hereafter, partners) and (2) electronic health records (EHR) obtained through the County's Avatar system. The County currently has four comprehensive FSP providers: Edgewood Center and Fred Finch Youth Center (hereafter, Edgewood/Fred Finch),[1] serving children, youth, and transitional age youth (TAY), and Caminar and Telecare, serving adults and older adults. *This year's report includes self-reported data from Edgewood/Fred Finch and Caminar since FSP inception (2006). Telecare changed its EHR system for FSP program data in December 2018 and is having technical difficulties providing the data prior to the change of the EHR system. Because of this change, we report data for Telecare from December 2018 to June 2022 separately.*

Exhibits 1 and 2 presents outcomes for children (16 years and younger), TAY (16–25 years), adults (25 to 59 years), and older adults (60 years and older) (hereafter, partners) of the FSP program in the County. Self-reported FSP outcomes presented in Exhibits 1 and 2 were obtained only from Edgewood/Fred Finch and Caminar. Because of changes in the reporting systems for Telecare, its data are provided in Exhibit 4.

For all outcomes, we compared the year just prior to enrollment in an FSP and the first year enrolled in an FSP. Blue font in Exhibits 1 and 2 indicates a statistically significant positive percent change. Red (and bold) font indicates a statistically significant negative percent change (e.g., worse academic grades for children and TAY partners). Black font indicates that there was no change, or there is a non-statistically significant change from the year before and the first year of an FSP. Percent change is the change in the number of partners with the outcome of interest (e.g., homelessness, incarceration, mental health emergencies) in the year after joining an FSP relative to the year prior to participating in an FSP out of the total number of partners in that age group. For example, the number of adult partners experiencing homelessness changed from 47 before FSP enrollment to 34 in the first year following FSP enrollment, out of 114 adult

[1] The self-reported data from Edgewood Center and Fred Finch Youth Center are combined into one data set; therefore, we refer to both centers as Edgewood/Fred Finch in this report to be consistent with the data.

partners, which is a 28% improvement. We first provide self-reported and EHR outcomes for adults and older adults followed by child and TAY partners.

Self-Reported Outcomes (Caminar) for Adults and Older Adults. For adults and older adults, most self-reported outcomes improved from the year prior to enrollment to the first year enrolled in an FSP.

- Fourteen out of 16 outcomes improved for adult and older adult partners. Fewer adult and older adult partners experienced homelessness, detention or incarceration, arrests, mental and physical health emergencies, or substance use disorders. In addition, employment increased among adult partners. More adult partners reported having substance use disorder treatment in the first year of an FSP compared with the year before. Five out of the 14 improvements were statistically significant.
- No older adults reported being employed before and after they joined FSP.

Fewer partners reported receiving treatment for substance use disorder. However, we also see a decrease in reported active substance use, which may explain the decrease in reported treatment. **Health Care Utilization (EHR Data) for Adults and Older Adults.** For adult and older adult partners, we detected improvements in outcomes from the year before an FSP compared with the first year in an FSP for all health care utilization outcomes. Compared with the year before joining an FSP, there was a

- decrease in the percentage of partners with any hospitalization,
- decrease in mean hospital days per partner,
- decrease in percentage of partners using any psychiatric emergency services (PES), and
- decrease in mean PES event per partner.

These changes were all statistically significant for adults; only the change in use of PES was statistically significant for older adults.

Exhibit 1. Percent Change in Outcomes for Adults and Older Adults, Year Before FSP Compared With First Year With FSP

FSP outcomes	Adult (25 to 59 years)			Older adult (60 years and older)		
Self-reported outcomes	***N = 114***			***N = 23***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Homelessness	47 (41%)	34 (30%)	-28%	5 (22%)	3 (13%)	-40%
Detention or incarceration	35 (31%)	22 (19%)	-37%*	4 (17%)	3 (13%)	-25%
Employment	1 (1%)	4 (4%)	300%	0 (0%)	0 (0%)	N/A
Arrests	20 (18%)	4 (4%)	-80%*	4 (17%)	1 (4%)	-75%
Mental health emergencies	84 (74%)	31 (27%)	-63%*	13 (57%)	4 (17%)	-69%*
Physical health emergencies	50 (44%)	17 (15%)	-66%*	7 (30%)	4 (17%)	-43%
Active Substance Use Disorder (SUD)	61 (54%)	57 (50%)	-7%	5 (22%)	4 (17%)	-20%
SUD treatment	27 (24%)	33 (29%)	22%	3 (13%)	2 (9%)	-33%
Health care utilization (EHR data)	***N = 360***			***N = 75***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Hospitalization	125 (35%)	57 (16%)	-54%*	22 (29%)	12 (16%)	-45%
Hospital days per partner	12.4	4.0	-68%*	10.5	4.6	-57%
Psychiatric Emergency Services (PES)	196 (54%)	140(39%)	-29%*	32 (43%)	19 (25%)	-41%*
PES event per partner	1.7	1.1	-37%*	1.1	0.5	-51%

Note. Self-reported outcomes do not include Telecare Yr = year; Exhibit 1 indicates the change in the number of partners with outcome of interest, comparing the year just prior to FSP with the first year of FSP. Counts are presented in Exhibit 1 to indicate the number of partners with outcome of interest, and percentages are presented in parentheses. For example, in Yr before, there were 47 adults who experienced homelessness, which is 41% of all 114 adults. In the Yr after, there were 34 adults, which is 30% of all adults who experienced homelessness. For self-reported outcomes, there are only 23 older adult partners; therefore, caution is needed when interpreting the results with small sample size. The percent difference with employment for older adults is reported as N/A because the percentage of older partners with employment was 0% in the Yr before (from 0% to 0%). Thus, the denominator is 0. Blue font indicates outcomes that improved. Black font indicates outcomes did not change or changed but the change was not statistically significant. *Indicates a change significantly different from 0 at 0.05 significance level.

Self-Reported Outcomes (Edgewood/Fred Finch) for Child and TAY Partners. The trends for child and TAY partners are similar to those for adult and older adult partners (as shown in Exhibit 2), where most of the self-reported outcomes improved from the year prior to enrollment to the first year enrolled in an FSP.

- Twelve out of 16 outcomes improved for child and TAY partners. Fewer child and TAY partners experienced homelessness, arrests, mental and physical health emergencies, and school suspensions. There was an improvement on detention or incarceration and rating of school attendance among TAY partners. Among these 12 outcomes, eight improvements were statistically significant.
- One outcome, detention or incarceration, remained the same for child partners. However, for arrests, there were significant decreases between the year prior to FSP and the first year after FSP enrollment among child partners (14% vs. 5%).
- Three outcomes worsened for child or TAY partners. For child partners, there were (statistically significant) decreases between the year prior to FSP and the first year after FSP enrollment for both academic grades and attendance. TAY partners reported decreased academic grades during the first year after enrolling in an FSP program, but this change was not statistically significant.

Health Care Utilization (EHR Data) for Child and TAY Partners. For child and TAY partners, we detected improvements in outcomes from the year before FSP compared with the first year of FSP for all health care utilization outcomes. Compared with the year before joining an FSP, there was a:

- decrease in the percentage of partners with any hospitalization,
- decrease in mean hospital days per partner,
- decrease in percentage of partners using any PES, and
- decrease in mean PES event per partner.

These changes were statistically significant for child partners for all but mean hospital days per partner; only the change in use of PES was statistically significant for TAY partners.

Exhibit 2. Percent Change in Outcomes for Children and TAY, Year Before FSP Compared With First Year With FSP

FSP outcomes	Child (16 years and younger)			TAY (17 to 25 years)		
Self-reported outcomes	***N = 219***			***N = 264***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Homelessness	9 (4%)	7 (3%)	-22%	34 (13%)	32 (12%)	-6%
Detention or incarceration	28 (13%)	28 (13%)	0%	40 (15%)	32 (12%)	-20%
Arrests	30 (14%)	10 (5%)	-67%*	65 (25%)	20 (8%)	-69%*
Mental health emergencies	78 (36%)	8 (4%)	-90%*	119 (45%)	27 (10%)	-77%*
Physical health emergencies	16 (7%)	1 (0%)	-94%*	55 (21%)	5 (2%)	-91%*
Suspension	45 (21%)	20 (9%)	-56%*	26 (10%)	6 (2%)	-77%*
Grade	3.35	3.02	-10%*	3.22	3.14	-3%
Attendance	2.22	1.95	-12%*	2.40	2.49	4%
	N = 213			***N = 206***		
	Yr before	*Yr after*	*Change*	*Yr before*	*Yr after*	*Change*
Hospitalization	10 (5%)	3 (1%)	-70%*	25 (12%)	15 (7%)	-40%
Hospital days per partner	1.2	0.1	-91%	4.4	2.1	-53%
PES	52 (24%)	23 (11%)	-56%*	85 (41%)	53 (26%)	-38%*
PES event per partner	0.5	0.2	-55%*	1.0	0.8	-29%

Note. Yr = year. Exhibit 2 indicates the change in the number of partners with outcome of interest, comparing the year just prior to FSP with the first year of FSP. Counts are presented in Exhibit 2 to indicate the number of partners with outcome of interest, and percentages are presented in parentheses. Percent change in ratings indicates the change in the average rating for the first year on the program as compared with the year just prior to FSP. Blue font indicates outcomes that improved. Red (and bold) font indicates outcomes that worsened. Black font indicates outcomes did not change or changed but the change was not statistically significant. *Indicates a change significantly different from 0 at 0.05 significance level.

Exhibit 3 shows the hospitalization outcomes for partners across all age groups who joined the FSP program since 2006, completed 1 full year or more in an FSP program, and had health utilization data in the EHR. Among these partners, we looked at their mean health utilization outcomes in the first year of FSP and the year prior to FSP. Exhibits 19-22 show reductions in outcomes for health care utilization over the years since the inception of the FSP program.

Exhibit 3. FSP Partners Have Significantly Improved Hospitalization Outcomes (*N* = 854)

	Percentage/Mean	95% confidence interval
Percentage of partners with any hospitalization*		
1 year before	21%	(19%–24%)
Year 1 during	10%	(8%–12%)
Mean number of hospital days*		
1 year before	7.52	(6.01–9.03)
Year 1 during	2.61	(1.77–3.45)
Percentage of partners with any PES event*		
1 year before	43%	(39%–46%)
Year 1 during	28%	(25%–31%)
Mean PES events, per partner*		
1 year before	1.16	(1.01–1.32)
Year 1 during	0.72	(0.59–0.84)

* Significance testing was conducted using chi-square tests for percentages and *t* tests for means; results are statistically significant at the 5% level.

Because of the issue with Telecare's incomplete data noted earlier, we conducted a separate analysis for Telecare. Exhibit 4 shows self-reported outcomes among Telecare partners, for the year before FSP compared with the first year with FSP. There were 85 partners in the Telecare survey data who completed at least a year of an FSP between December 2018 through June 30, 2022. Our analysis combined all age groups (TAY, adults and older adults) served by Telecare for this separate analysis because of the small sample size. Exhibit 4 shows improvements for Telecare partners on homelessness, incarceration, arrests, and active substance use disorder, with the decreases in these negative events being statistically significant for all but homelessness. No change was observed for employment outcomes of Telecare partners. Telecare partners had poorer outcomes after joining an FSP in two outcome areas: more Telecare partners reported having mental and physical health emergencies in the first year of an FSP compared to the year prior to FSP. Fewer partners reported receiving treatment for substance use disorder. However, we also see a decrease in reported active substance use, which may explain the decrease in reported treatment. The change was statistically significant only for the increased experience of mental health emergencies.

Exhibit 4. Percent Change in Outcomes Among Telecare Partners, Year Before FSP Compared With First Year With FSP

FSP *Self-reported outcomes*	Everyone *N* = 85		
	Yr before	*Yr after*	*Change*
Homelessness	24 (28%)	19 (22%)	-21%
Detention or incarceration	17 (20%)	4 (5%)	-76%*
Employment	0 (0%)	0 (0%)	N/A
Arrests	22 (26%)	8 (9%)	-64%*
Mental health emergencies	16 (19%)	31 (36%)	**94%***
Physical health emergencies	11 (13%)	12 (14%)	9%
Active S.U. disorder	49 (58%)	31 (36%)	-37%*
S.U. treatment	7 (8%)	3 (4%)	-57%

Note. S.U. = substance use. Yr = year. Exhibit 4 indicates the change in the percentage of partners with any events, comparing the year just prior to FSP with the first year with FSP. The percent difference with employment is reported as N/A because the percentage of partners with employment in the year before is 0%, and it did not change (from 0% to 0%). Thus, the denominator is 0. Blue font indicates outcomes that improved. Red (and bold) font indicates outcomes that worsened. Black font indicates outcomes did not change or changed but the change was not statistically significant. *Indicates a change significantly different from 0 at 0.05 significance level.

Background and Introduction

The Mental Health Services Act (MHSA), enacted in 2005, provides a dedicated source of funding to improve the quality of life for individuals living with mental illness. In San Mateo County (the County), a large component of this work is accomplished through full-service partnerships (FSPs). FSP programs provide individualized integrated mental health services, flexible funding, intensive case management, and 24-hour access to care ("whatever it takes" model) to help support recovery and wellness for persons with serious mental illness (SMI) and their families. There are currently four comprehensive FSP providers in the County: Edgewood Center and Fred Finch Youth Center (hereafter, Edgewood/Fred Finch),[2] serving children, youth, and transitional age youth (TAY), and Caminar and Telecare, serving adults and older adults.

[2] The self-reported data from Edgewood Center and Fred Finch Youth Center are combined into one data set; therefore, we refer to both centers as Edgewood/Fred Finch in this report to be consistent with the data.

The County has partnered with the American Institutes for Research (AIR) to understand how enrollment in an FSP is promoting resiliency and improving health outcomes of the County's clients living with mental illness. Two data sources are used for this report: (1) self-reported survey data collected by providers from FSP clients (hereafter, partners) and (2) electronic health records (EHR) obtained through the County's Avatar system.

This year's report includes self-reported data from all Edgewood/Fred Finch and Caminar providers since FSP inception (2006). Telecare changed its EHR system for FSP program data in the middle of 2018 and is having technical difficulties providing the data prior to the change of the EHR system. Because of this change, we report data from Telecare from December 2018 to June 2022 separately.

Providers collect initial survey data through an intake assessment, called the Partnership Assessment Form (PAF), which includes information on well-being across a variety of measures (e.g., living in a residential setting) at the start of FSP and over the 12-month "lookback" window of the year prior to FSP enrollment. Providers gather survey data on partners during their participation in an FSP in two ways. Life-changing events are tracked by Key Event Tracking (KET) forms, which are triggered by any key event (e.g., a change in residential setting). Partners are also assessed regularly with 3-Month (3M) forms. Changes in partner outcomes are gathered by comparing data on baseline from PAF forms to follow-up data from KET and 3M forms.

EHR data collected through the County Avatar system contain longitudinal partner-level information on demographics, FSP program participation, hospitalizations, and psychiatric emergency services (PES) utilization before and after FSP enrollment. The Avatar system is limited to individuals who obtain emergency care in the County hospitals. Hospitalizations outside of the County, or in private hospitals, are not captured.

This report presents changes in partners' self-reported and hospitalization outcomes in two consecutive years: (1) the baseline year, that is, the 12 months prior to enrollment in an FSP program, and (2) the first full 12 months of the partner's FSP participation. Children (ages 16 and younger), transitional age youth (TAY; ages 17 to 25), adults (ages 25 to 59), and older adults (ages 60 and older) were included in the analysis if they had completed at least 1 full year with an FSP program by June 30, 2022 (the data acquisition date). Trends in EHR data are subsequently presented as an average across all years since inception of the program (2006) as well as annually, by year of FSP program enrollment.

Appendices provide details on our methodology as well as detailed findings for each outcome. Appendix A presents additional detail on residential outcomes. Appendix B provides outcomes

for individual FSP providers. Appendix C provides methodology for both the self-reported outcomes and the EHR-based hospitalization outcomes.

Self-Reported Outcomes

Overview

This section presents outcomes for 705 FSP partners in total across four FSP providers. The results presented in this section compare the first year enrolled in an FSP with the year just prior to FSP enrollment for partners completing at least 1 year in an FSP program.

- The Caminar section presents outcomes for 114 adult (ages 26–59) FSP partners; and 23 older adult (ages 60 and older) FSP partners who joined and completed at least 1 year in FSP since 2006. [3]
- The Edgewood/Fred Finch section below presents outcomes for 219 child (ages 16 and younger) FSP partners and 264 TAY (ages 17–25) FSP partners. the Caminar.
- The Telecare section presents outcomes for 85 FSP partners regardless of age. Because of the small sample size, we have combined findings for all age groups when reporting findings for Telecare partners.

Telecare changed its EHR system on December 1, 2018 and was only able to provide the data after the conversion date as a result of data reliability issues. Because of the incompleteness of the Telecare data, we conducted a separate analysis for Telecare.

In this section, we first provide a list of self-reported outcomes collected by all providers. We then present findings from the analysis of Caminar and Edgewood/Fred Finch combined data since FSP inception, followed by findings from the analysis using Telecare data since December 2018.

Outcomes Assessed

We describe the self-reported outcomes below. Most of these outcomes are broken down by age group. Note that employment, homelessness, arrests, and incarceration outcomes are not presented for adults ages 60 or older, as there are insufficient observations in this age group for meaningful interpretation.

[3] Caminar's self-reported data also includes 55 TAY (ages 17-25), however, we exclude them from the analysis due to lack of ongoing data collection.

1. **Partners with any reported homelessness incident:** measured by residential setting indicating homelessness or emergency shelter (sources: PAF and KET)
2. **Partners with any reported detention or incarceration incident:** measured by residential setting indicating jail or prison (sources: PAF and KET)
3. **Partners with any reported employment**: measured by employment in past 12 months and date of employment change (sources: PAF and KET)[4]
4. **Partners with any reported arrests:** measured by arrests in past 12 months and date arrested (sources: PAF and KET)
5. **Partners with any self-reported mental health emergencies:** measured by emergencies in past 12 months and date of mental health emergency (sources: PAF and KET)
6. **Partners with any self-reported physical health emergencies:** measured by emergencies in past 12 months and date of acute medical emergency (sources: PAF and KET)
7. **Partners with any self-reported active substance use disorder:** measured by self-report in past 12 months and captured again in regular updates (sources: PAF and 3M)
8. **Partners in substance use disorder treatment:** measured by self-report in past 12 months and captured again in regular updates (sources: PAF and 3M)[5]

In addition, we also examined three outcomes specific to child and TAY partners:

1. **Partners with any reported suspensions:** measured by suspensions in past 12 months (source: PAF) and date suspended (source: KET)
2. **Average school attendance self-rating:** an ordinal ranking (1–5) indicating overall attendance; measured for past 12 months (source: PAF), at start of FSP (source: PAF), and over time on FSP (source: 3M)
3. **Average school grade self-rating:** an ordinal ranking (1–5) indicating overall grades; measured for past 12 months (source: PAF), at start of FSP (source: PAF), and over time on FSP (source: 3M)

Mental and Physical Health Emergencies by Living Situation. Mental and physical health emergencies are considered in conjunction with residential status for all age groups combined. Specifically, we explore the likelihood of an emergency in relation to whether the partner's living situation in their first year of FSP participation is "advantageous" (i.e., living with family or

[4] Employment outcome is not applicable to child and TAY partners.
[5] If more partners reported receiving substance use disorder treatment in the year following their FSP enrollment, it may indicate that the integrated care and case management services offered through FSP connected partners with needed care. However, if more partners have substance use disorder, there would be more partners reporting receiving treatment.

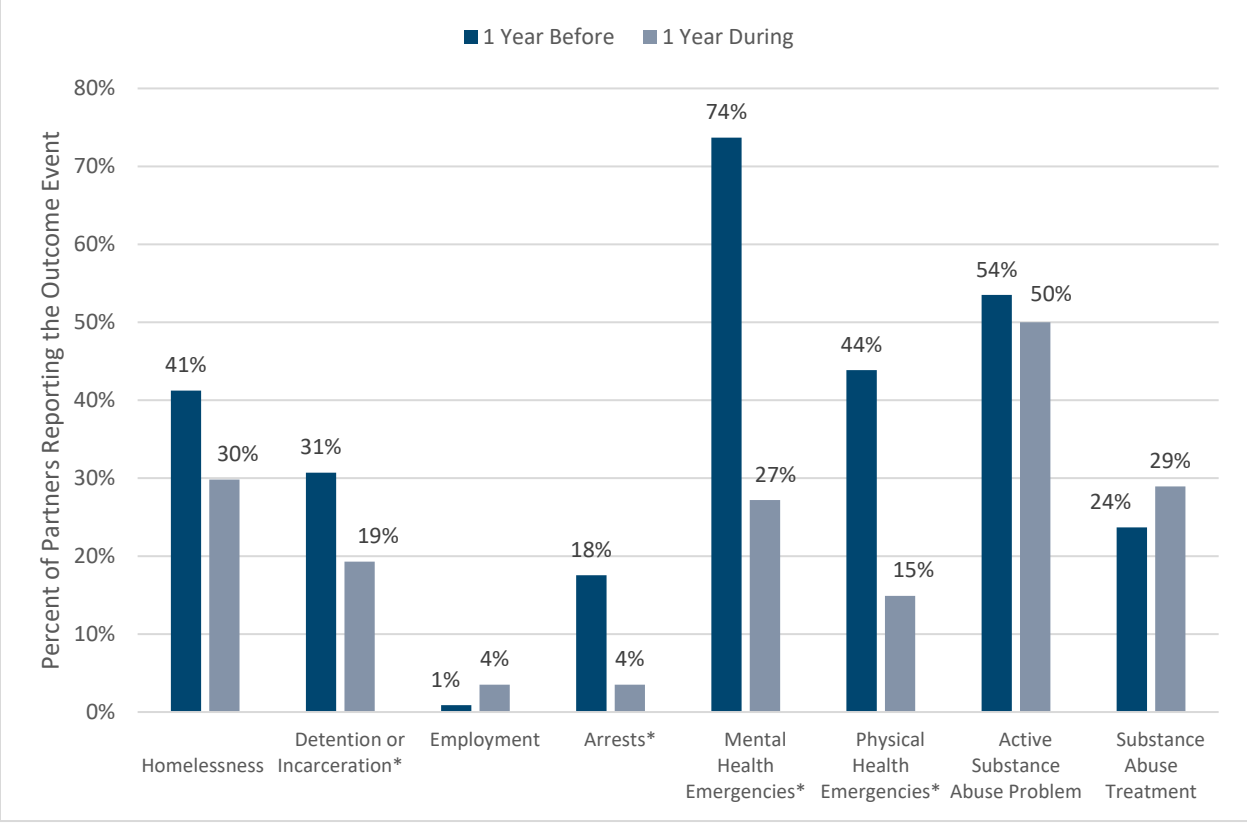
foster family, living along and paying rent, or living in group care or assisted living) or "higher risk" (i.e., homeless, incarcerated, or in a hospital setting).

Caminar

Self-Reported Outcomes by Age Group

Adults. Exhibit 5 compares outcomes for adult partners (ages 26–59) in the year prior to FSP enrollment with the first year in an FSP. Homelessness, incarceration, arrests, self-reported mental and physical health emergencies, and substance use problems decreased. In addition, employment and reported treatment of substance use disorder increased. These findings demonstrate improvements for adult partners in the first year of FSP enrollment for all outcomes. The improvements for detention or incarceration, arrests, and mental and physical health emergencies are statistically significant.

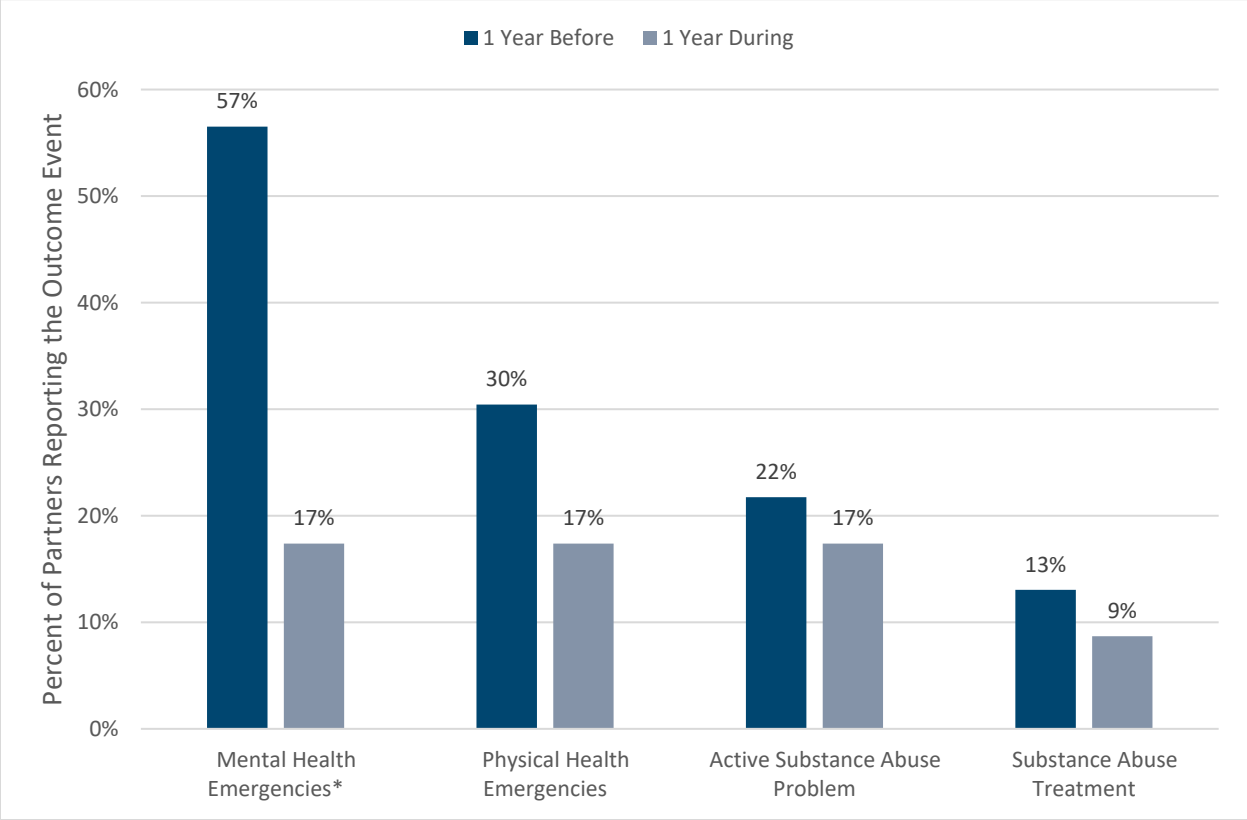
Exhibit 5. Outcomes for Adult Partners Completing 1 Year With FSP (*N* = 114)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Older Adults. Exhibit 6 compares outcomes in the year prior to FSP enrollment with outcomes reported in the first year of FSP enrollment for older adult partners (age 60 and above). Similar to adult partners, self-reported mental and physical health emergencies as well as substance use problems all decreased. Each of these demonstrated improvement for older adult partners in the first year of FSP enrollment. Slightly fewer older adults (from three in the year prior to two in the first year of FSP) reported treatment for a substance use disorder during the first year of FSP enrollment compared with 1 year before. Given the small sample size, these results are inconclusive. The decrease in mental health emergencies is the only statistically significant outcome for older adults.

Exhibit 6. Outcomes for Older Adult Partners Completing 1 Year With FSP (*N* = 23)

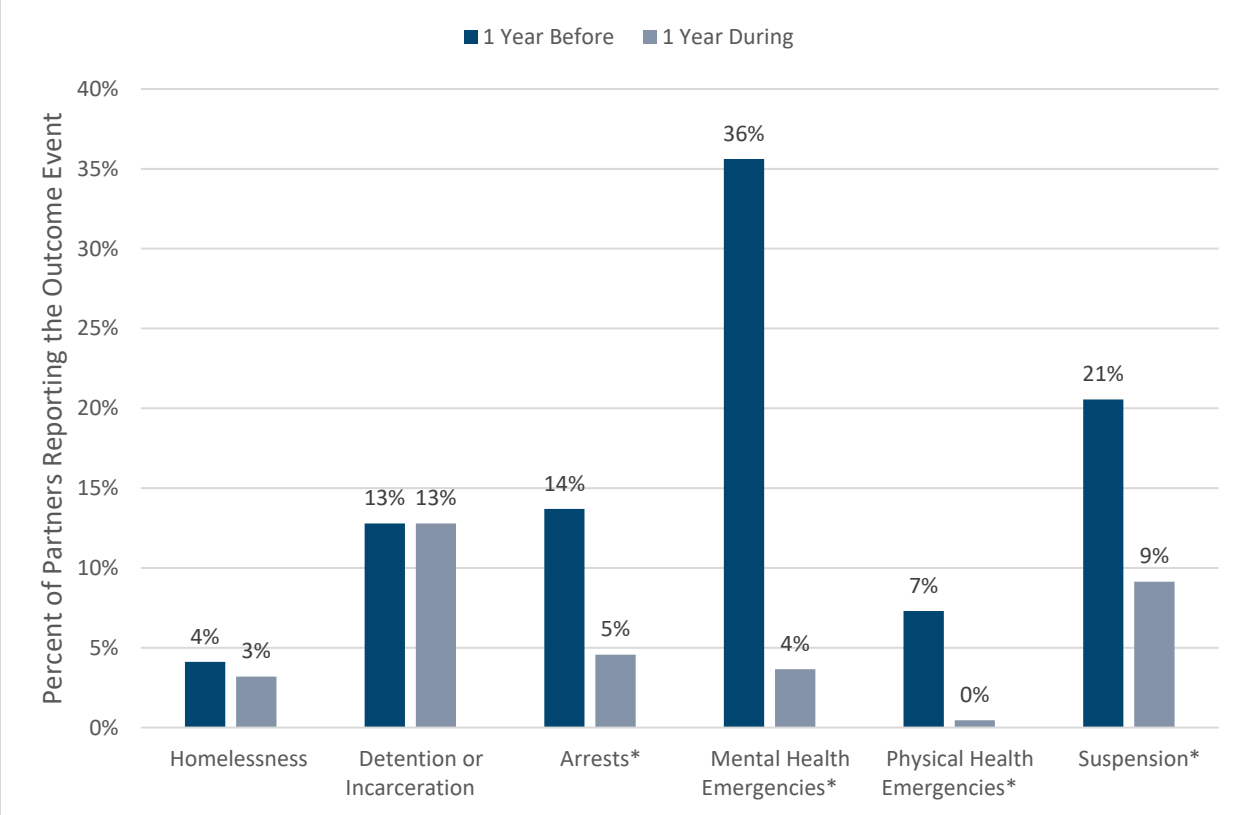


Note. Employment, homelessness, arrests, and incarceration outcomes are not presented for older adults, as there are insufficient observations in this age group for meaningful interpretation. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Edgewood/Fred Finch

Children. Exhibit 7 shows the comparison of outcomes in the year prior to FSP enrollment with the first year enrolled in an FSP program for child partners (age 16 and younger). There was a decrease in homelessness, arrests, suspensions, and mental or physical health emergencies after enrollment in an FSP program. In particular, there is a significant decrease in the incidence of mental health emergencies from the year prior to the first year of FSP (56% vs. 17%). Conversely, detention or incarceration remained the same for children (28 incidents in the first year with FSP and 28 in the year prior to FSP enrollment). However, the incidence of arrests reduced after enrollment in FSP (10 in the first year with FSP compared with 30 in the year just prior). The improvements for arrests, mental and physical health emergencies, and school suspensions are statistically significant.

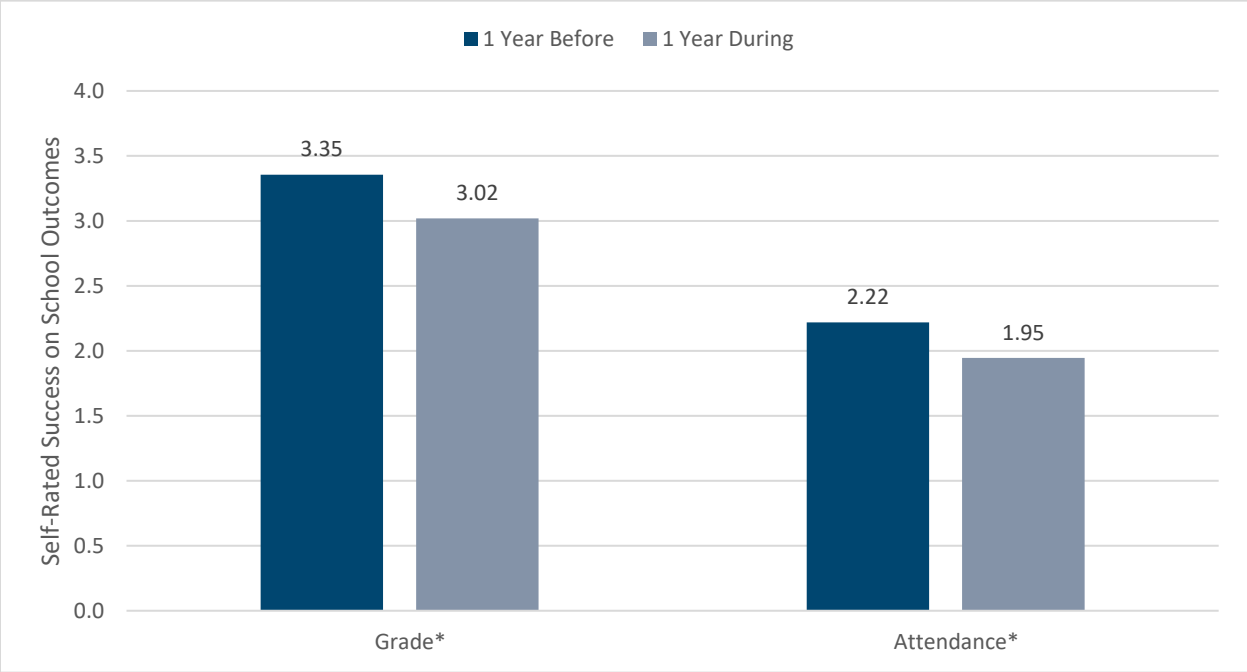
Exhibit 7. Outcomes for Child Partners Completing 1 Year With FSP (*N* = 219)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Exhibit 8 presents outcomes on school attendance and grades. School attendance and grades for child partners declined modestly after enrolling in an FSP program. These ratings are on a 1–5 scale, coded such that a higher score is better. The decreases in school attendance and grade are statistically significant.

Exhibit 8. School Outcomes for Child Partners Completing 1 Year With FSP (*N* = 219)

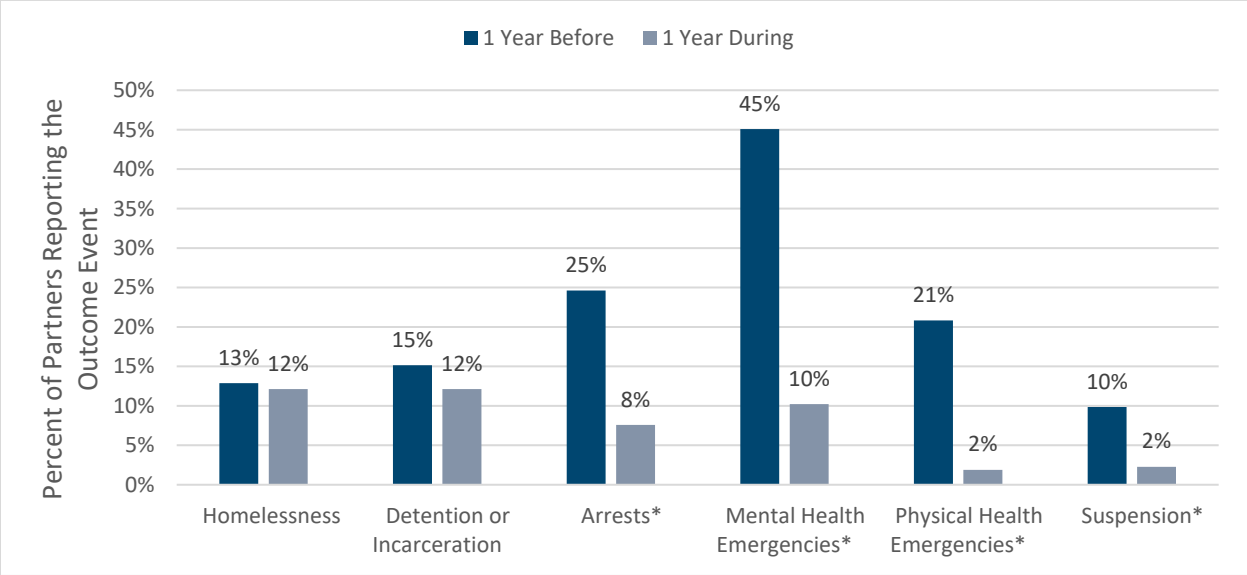


Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level. The ratings are on a 1–5 scale, coded such that a higher score is better.

TAY. Exhibit 9 shows the comparison of outcomes in the year prior to FSP to the first year in the program for TAY partners.[6] All self-reported outcomes decreased (an improved status), among which improvements on arrest, mental and physical health emergencies, as well as school suspensions are statistically significant.

[6] The older TAY partners in Caminar are excluded from these outcomes because these providers do not reliably gather TAY-specific outcomes. Note that employment as an outcome is not presented for TAY because many of these individuals are in school.

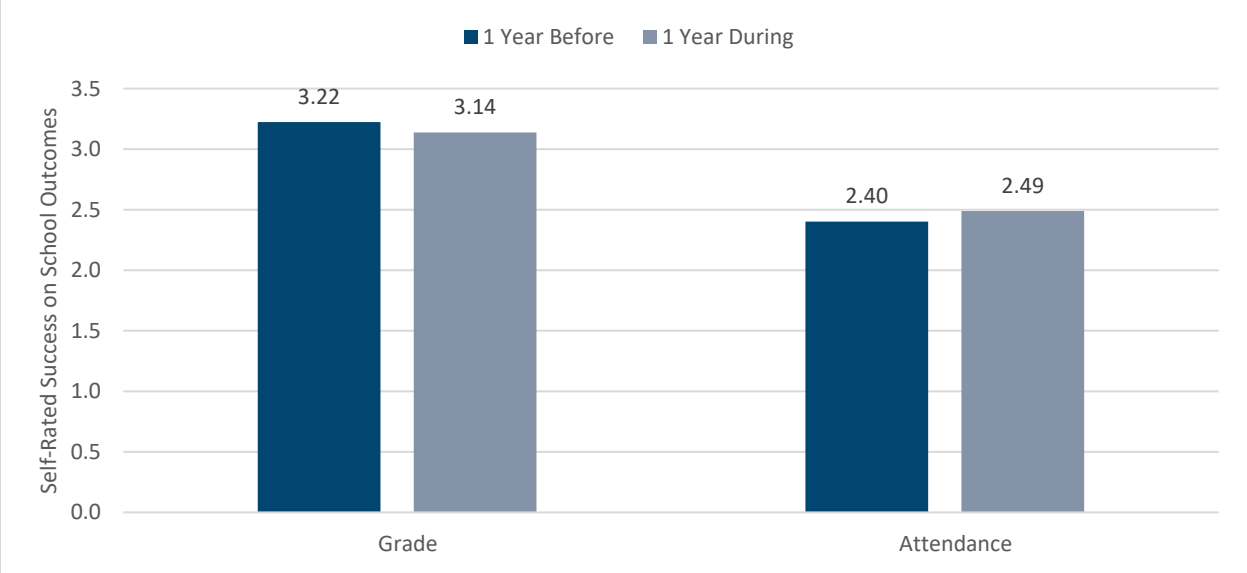
Exhibit 9. Outcomes for TAY Partners Completing 1 Year With FSP (*N* = 264)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Exhibit 10 shows outcomes on school attendance and grades for TAY partners. These ratings are on a 1–5 scale; a higher score is better. There was a small decrease in grades and a slight increase in attendance after enrollment in an FSP. Both outcomes are not statistically significant.

Exhibit 10. School Outcomes for TAY Partners Completing 1 Year With FSP (*N* = 264)

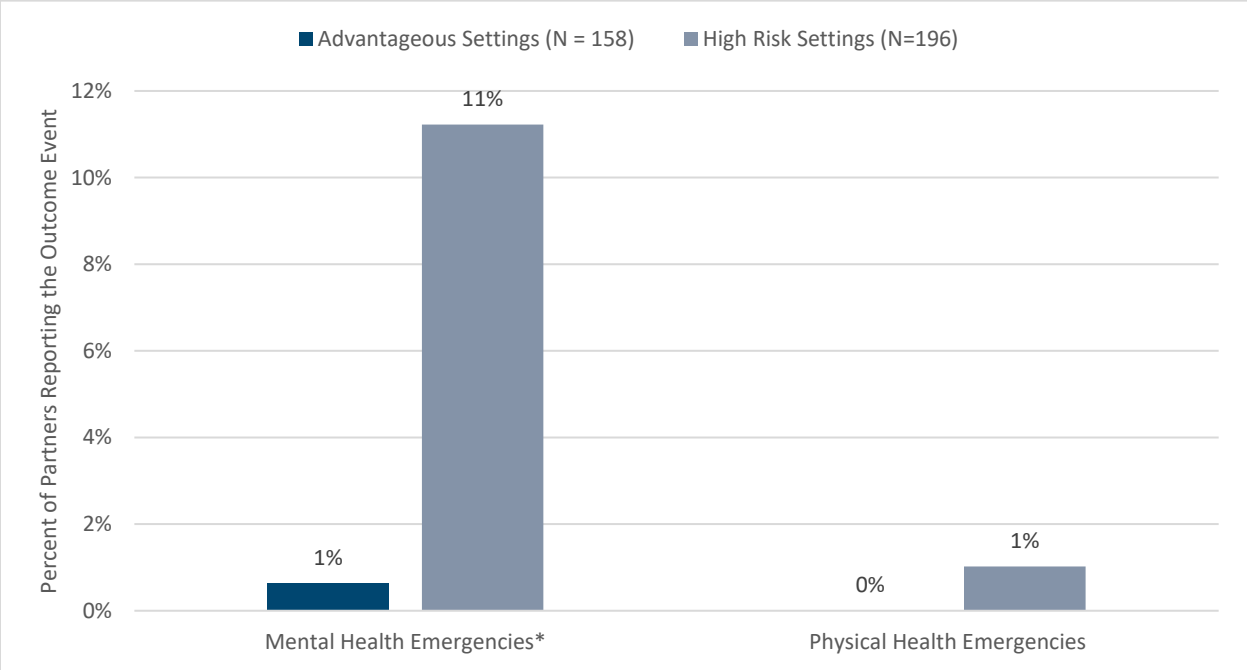


Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level. The ratings are on a 1–5 scale; a higher score is better.

Mental and Physical Health Emergencies by Living Situation

Exhibit 11 shows the mental and physical health emergencies in adult and older adult partners living in advantageous versus higher risk living situations in the first year of participating in an FSP. Advantageous settings are defined as living with family or foster family, living alone and paying rent, or living in group care or assisted living. High-risk settings are defined as homelessness, incarceration, or in a hospitalized setting. As shown in the exhibit, both mental and physical health emergencies were more common among individuals in a high-risk residential setting in their first year of FSP participation. The difference between advantageous setting and high-risk setting is statistically significant for mental health emergencies.

Exhibit 11. Emergency Outcomes as a Function of Residential Setting



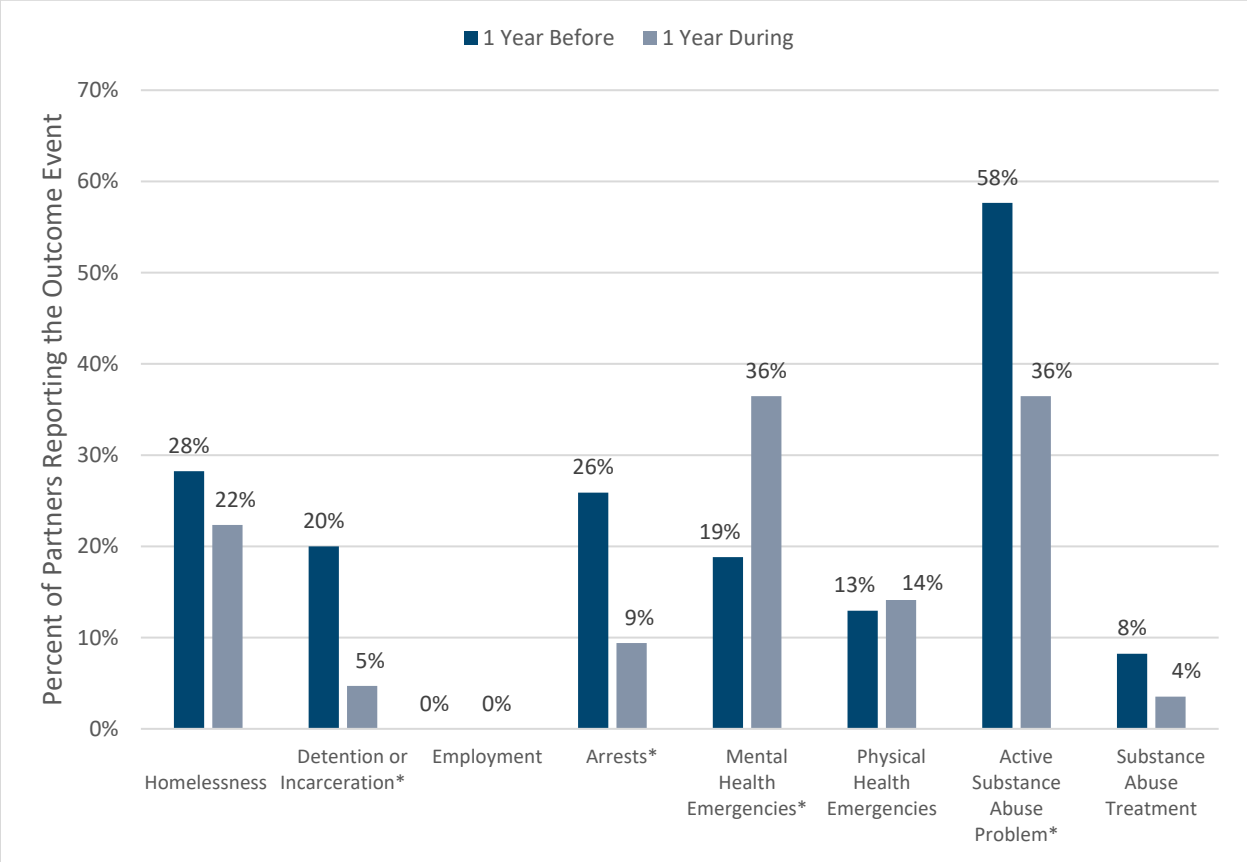
Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Telecare

Self-Reported Outcomes—All Age Groups

Telecare data include 85 partners who have completed at least 1 year of FSP as of June 30, 2022. Because of the small sample size, we have combined findings for all age groups. Exhibit 12 shows the comparison of outcomes for all Telecare partners in the year prior to FSP enrollment with the first year in an FSP. Homelessness, detention or incarceration, arrests, and substance use disorders all decreased after enrollment in an FSP. Each of these outcomes demonstrates improvements for partners in the first year of FSP enrollment. Mental and physical health emergencies were higher in Telecare partners a year after enrollment in an FSP program. In addition, fewer Telecare partners reported receiving treatment for substance use disorders 1 year during the FSP program compared with 1 year before enrollment. However, we also see a decrease in reported active substance use, which may explain the decrease in reported treatment. The outcomes for detention or incarceration, arrests, mental health emergencies, and active substance abuse problems are statistically significant.

Exhibit 12. Outcomes for Telecare Partners Completing 1 Year With FSP (*N* = 85)

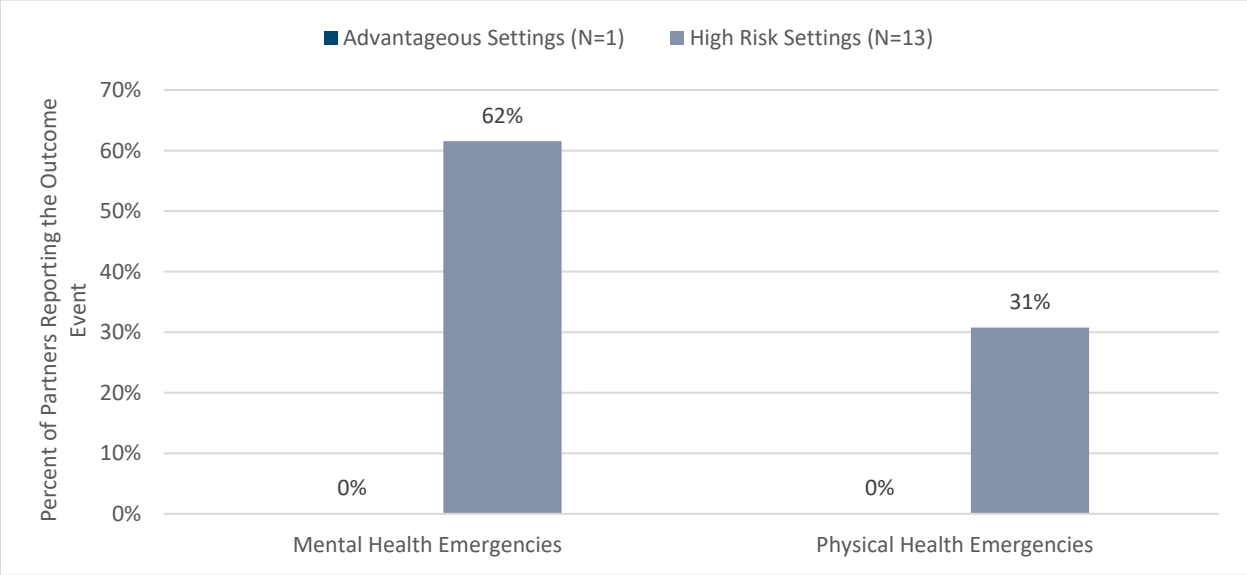


Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Mental and Physical Health Emergencies by Living Situation

Exhibit 13 shows the mental and physical health emergencies in adult and older adult partners living in advantageous versus higher risk living situations in the first year of an FSP. Mental and physical health emergencies only happened with individuals who lived in at least one high-risk residential setting in their first year of FSP participation; there were no mental or physical health emergencies for adult and older adult partners only living in advantageous situations, though the sample size for this subgroup is small (*N* = 1).

Exhibit 13. Emergency Outcomes as a Function of Residential Setting Among Telecare Partners



Health Care Utilization Overall and Over Time

Overview

This section describes (a) overall health care utilization across all partners from the beginning of an FSP program, (b) health care utilization by age group from the beginning of an FSP program, and (c) health care utilization for partners by year (2006–2022).

Using the County's EHR data, we present four hospitalization outcomes for 854 total FSP partners including213 child, 206 TAY, 360 adult, and 75 older adult FSP partners:

1. **Partners with any hospitalizations:** measured by any hospital admission in the past 12 months
2. **Partners with any PES:** measured by any PES event in the past 12 months

3. **Average length of hospitalization (in days):** the number of days associated with a hospital stay in the past 12 months
4. **Average number of PES event:** the number of PES events in the past 12 months

Overall Health Care Utilization Outcomes Across All Partners

We detected statistically significant changes in outcomes from the year before FSP compared with the first year in FSP for all hospitalization outcomes (Exhibit 14). Percentage of partners with any hospitalization decreased from 21% before FSP to 10% during FSP. The average number of days spent in the hospital decreased from 7.52 days before FSP to 2.61 days during FSP. Percentage of partners with any PES decreased from 43% before FSP to 28% during FSP. The average number of PES events decreased from 1.16 events before FSP to 0.72 events during FSP.

Exhibit 14. FSP Partners Have Significantly Improved Hospitalization Outcomes (*N* = 854)

	Percentage/Mean	95% confidence interval
Percentage of partners with any hospitalization*		
1 year before	21%	(19%–24%)
Year 1 during	10%	(8%–12%)
Mean number of hospital days*		
1 year before	7.52	(6.01–9.03)
Year 1 during	2.61	(1.77–3.45)
Percentage of partners with any PES event*		
1 year before	43%	(39%–46%)
Year 1 during	28%	(25%–31%)
Mean PES events, per partner*		
1 year before	1.16	(1.01–1.32)
Year 1 during	0.72	(0.59–0.84)

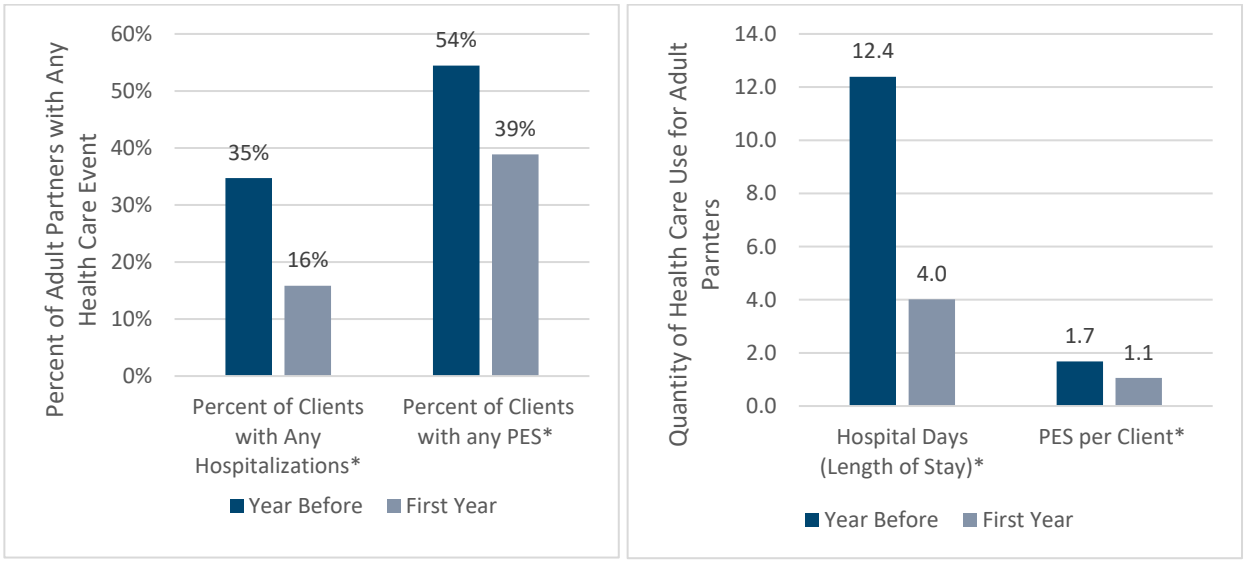
* Significance testing was conducted using chi-square tests for percentages and *t* tests for means; results are statistically significant at the 5% level.

Health Care Utilization for FSP Partners by Age Group

Hospitalization outcomes are presented in Exhibits 15–18 by age group. For all four age groups, the percentage of FSP partners with any hospitalization or PES event decreased after joining an FSP. The mean number of hospital days experienced by FSP partners and average number of PES events also decreased after FSP enrollment for all age groups. All four outcomes are

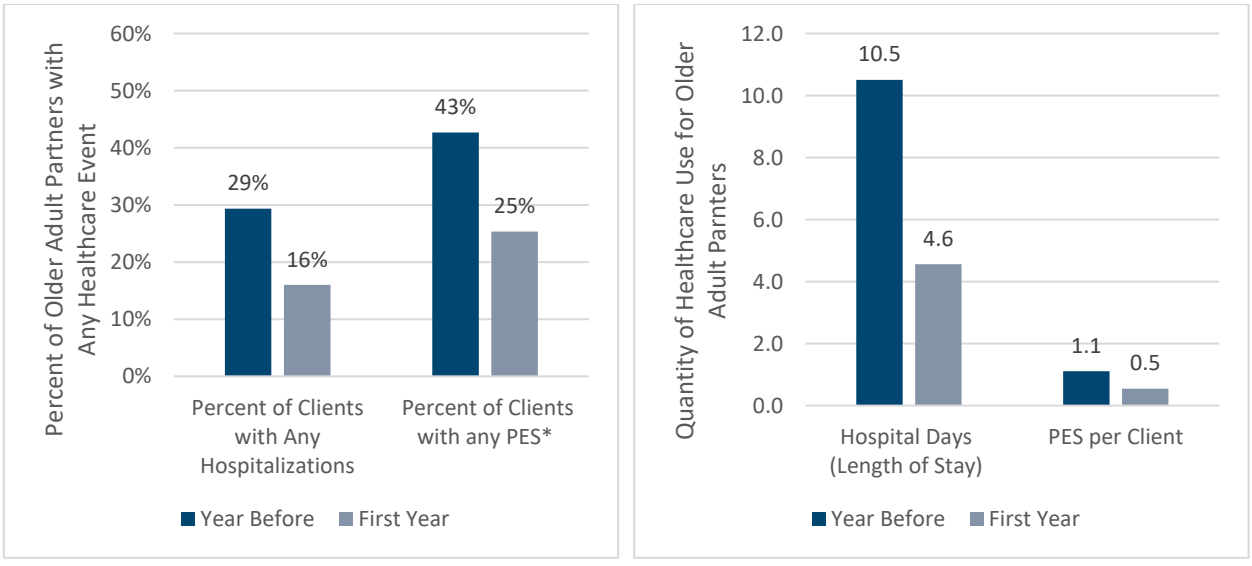
statistically significant for adults. All but the outcome on mean hospital stay are statistically significant for children. For older adults and TAY, only the outcome on percentage of partners with PES is statistically significant.

Exhibit 15. Hospitalization and PES Outcomes for Adult Partners Completing 1 Year With FSP (*N* = 360)



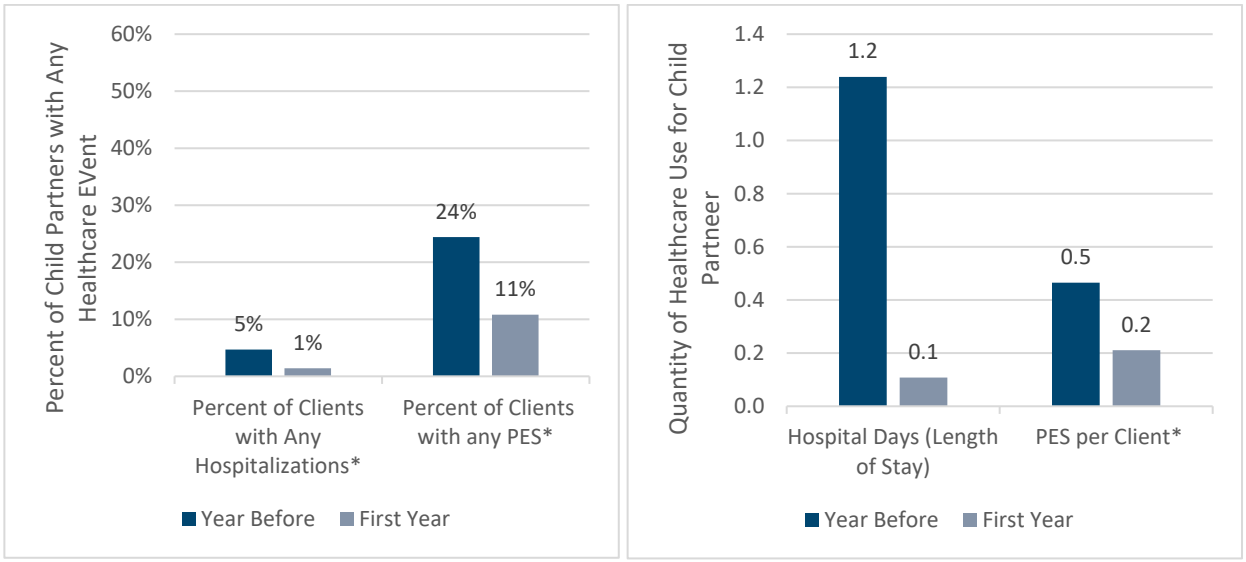
Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Exhibit 16. Hospitalization and PES Outcomes for Older Adult Partners Completing 1 Year With FSP (*N* = 75)



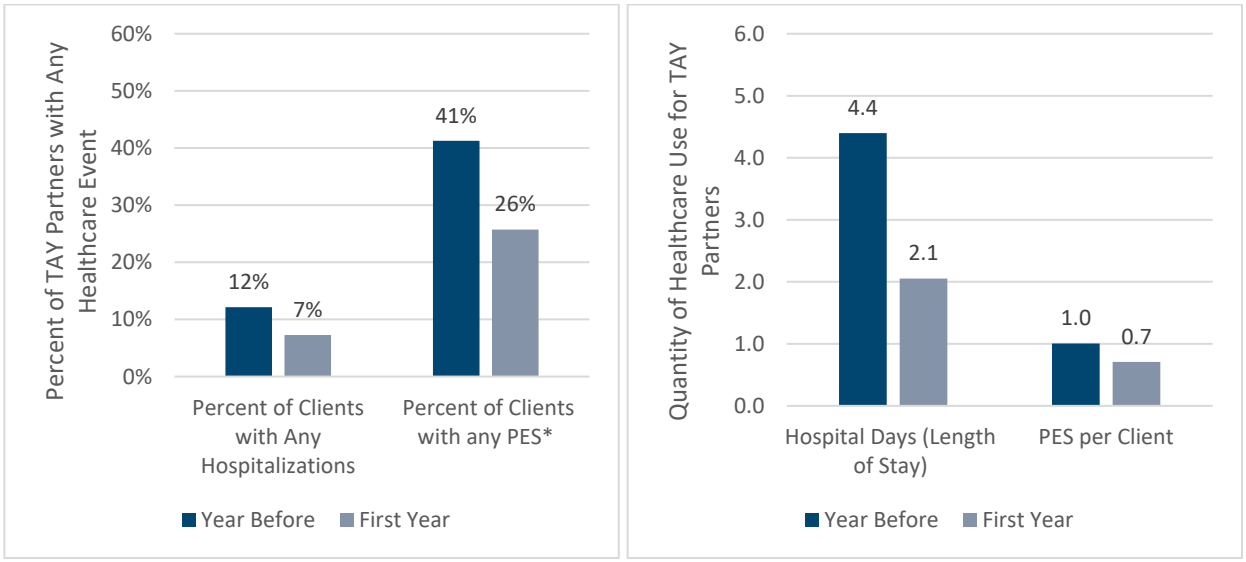
Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Exhibit 17. Hospitalization and PES Outcomes for Child Partners Completing 1 Year With FSP (*N* = 213)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Exhibit 18. Hospitalization and PES Outcomes for TAY Partners Completing 1 Year With FSP (*N* = 206)



Note. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Health Care Utilization for FSP Partners Over Time

Exhibits 19–22 show the four health care utilization outcomes, including the percentage of partners with any hospitalization, mean hospital days per partner, percentage of partners using any PES, and mean PES event per partner, stratified by enrollment year. As Exhibit 19 shows, the percentage of partners with any hospitalization decreased after joining an FSP program for all enrollment year cohorts.

Exhibit 19. Percentage of Partners With Any Hospitalization by FSP Enrollment Year

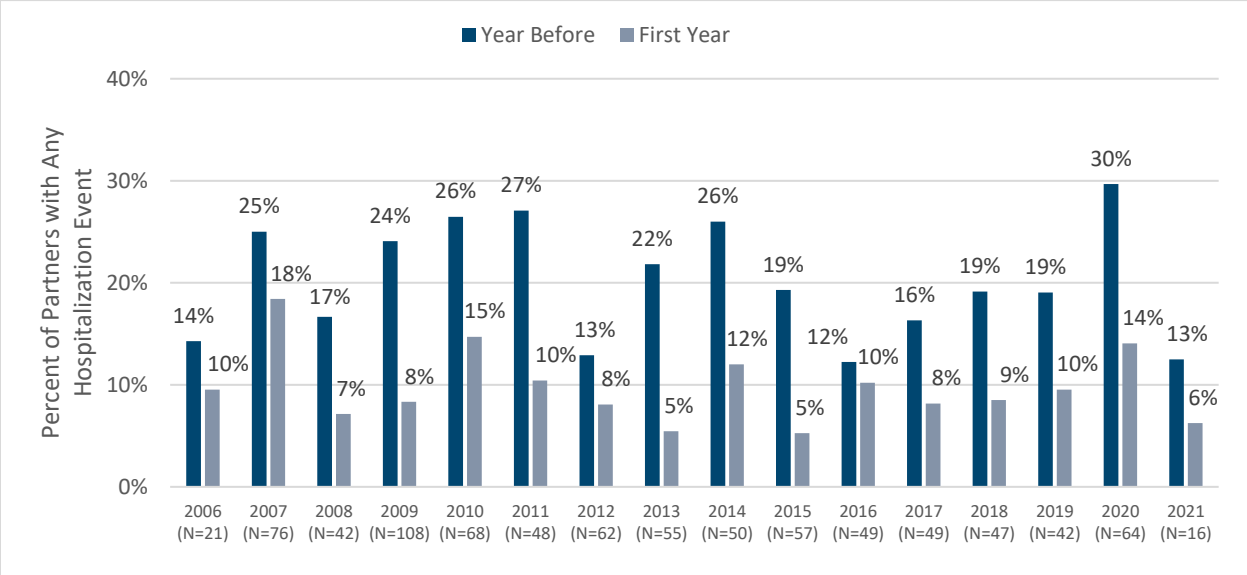


Exhibit 20 displays the mean hospital days per partner by enrollment year. With the exception of the 2006 and 2007 cohorts, all years show a decrease in the average hospital days.

Exhibit 20. Mean Number of Hospital Days by FSP Enrollment Year

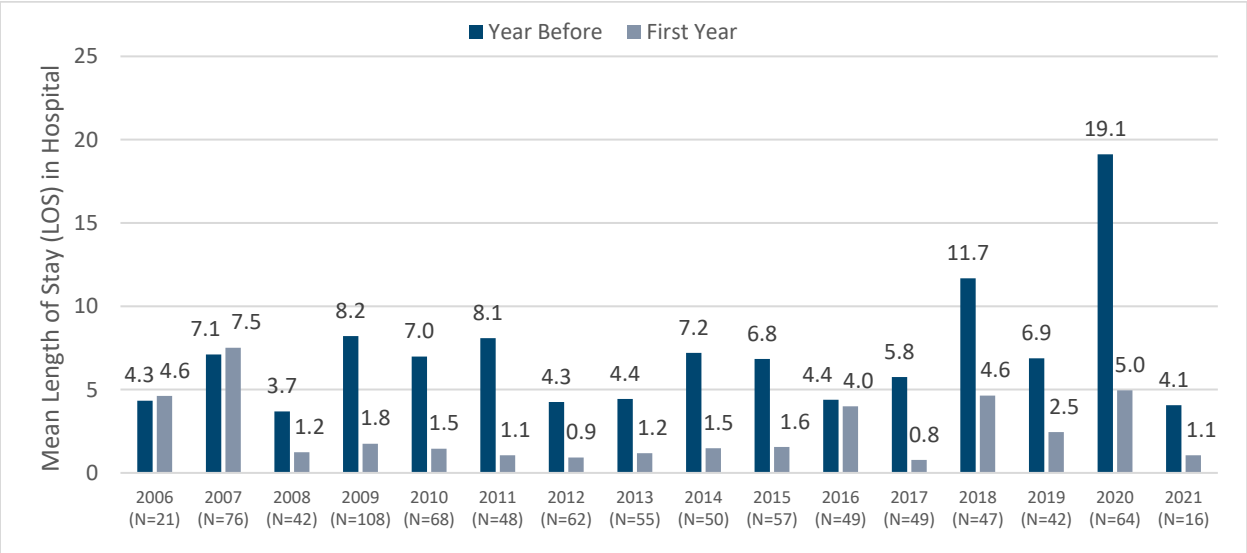


Exhibit 21 displays the percentage of partners with any PES event by the year they began FSP. All cohorts experienced a decline in the likelihood of a PES event.

Exhibit 21. Percentage of Partners With Any PES Event by FSP Enrollment Year

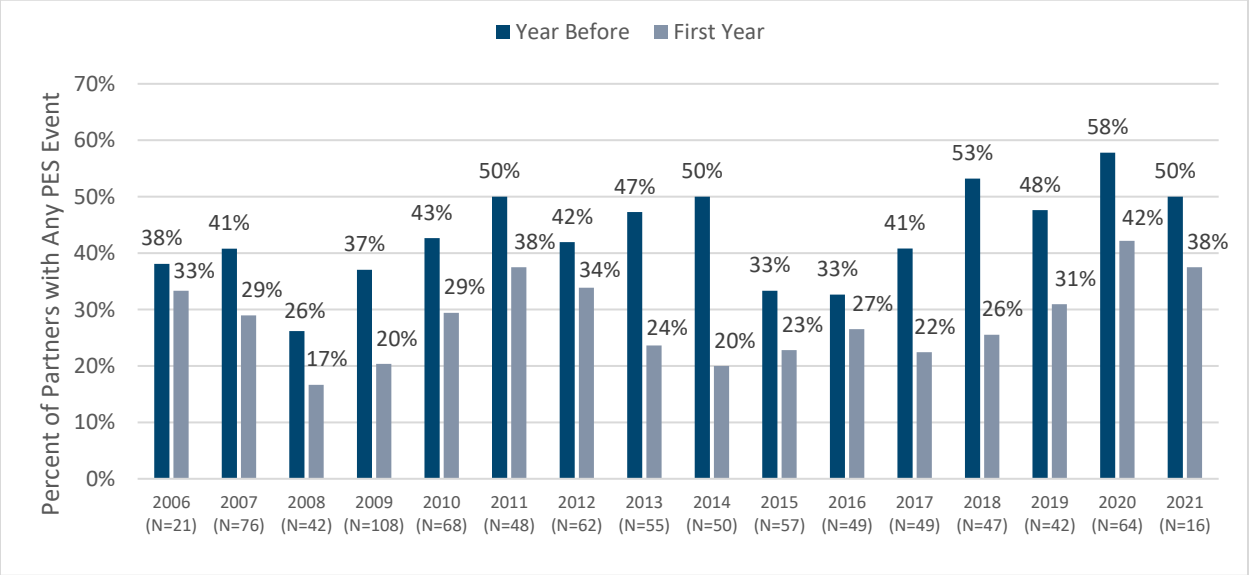
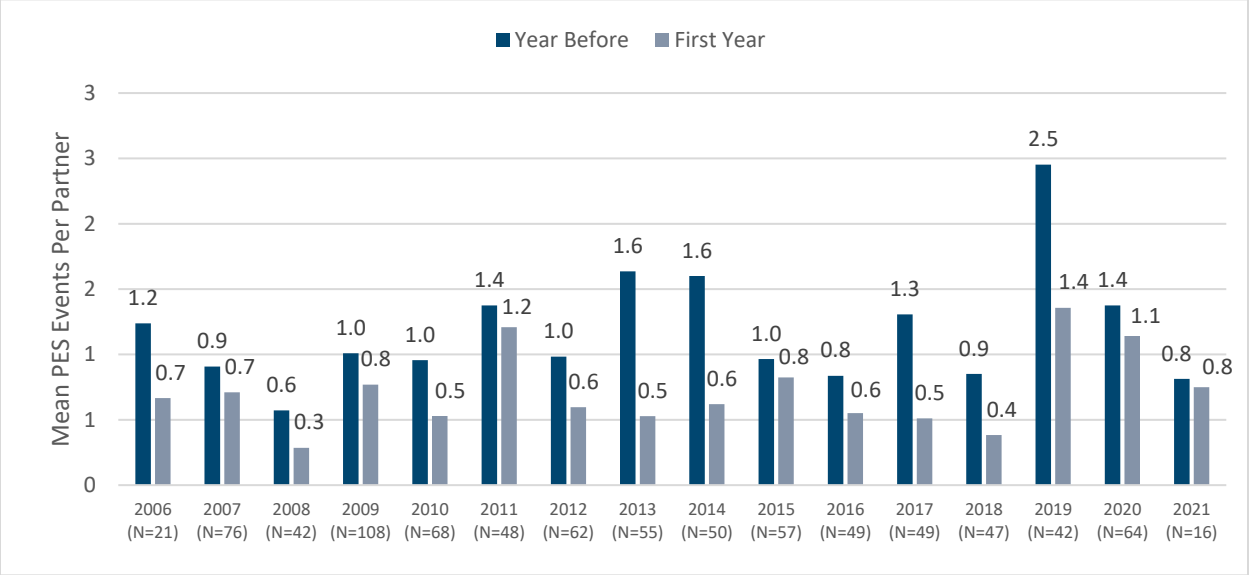


Exhibit 22 displays the mean PES events per partner by FSP enrollment year. All cohorts experienced a reduction in PES events.

Exhibit 22. Mean PES Events by FSP Enrollment Year

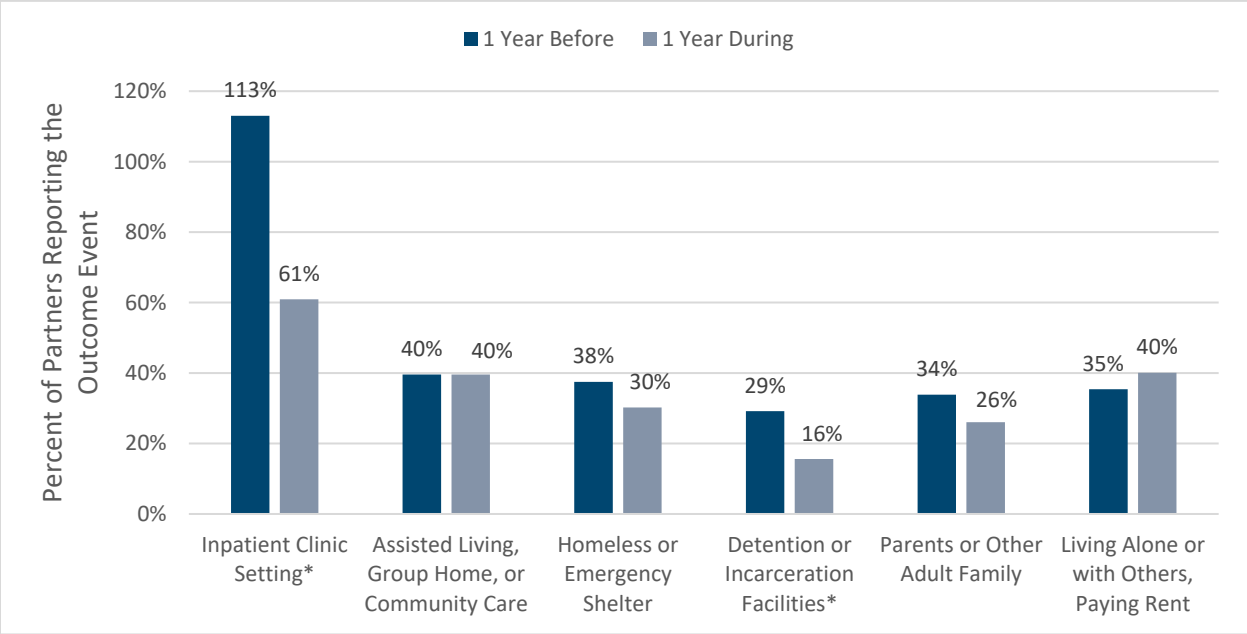


Appendix A. Additional Detail on Residential Outcomes

For residential setting outcomes, by full-service partnership (FSP) provider, we present all the categories of living situations and compare the percentages of any partners spending any time in various residential settings the year prior to FSP and in the first year of FSP participation. There are currently four comprehensive FSP providers in San Mateo County (the County): Edgewood Center and Fred Finch Youth Center (hereafter, Edgewood/Fred Finch), serving children, youth, and transitional age youth, and Caminar and Telecare, serving adults and older adults. A list of all residential settings and how they are categorized is presented in Appendix C with the methodological approach.

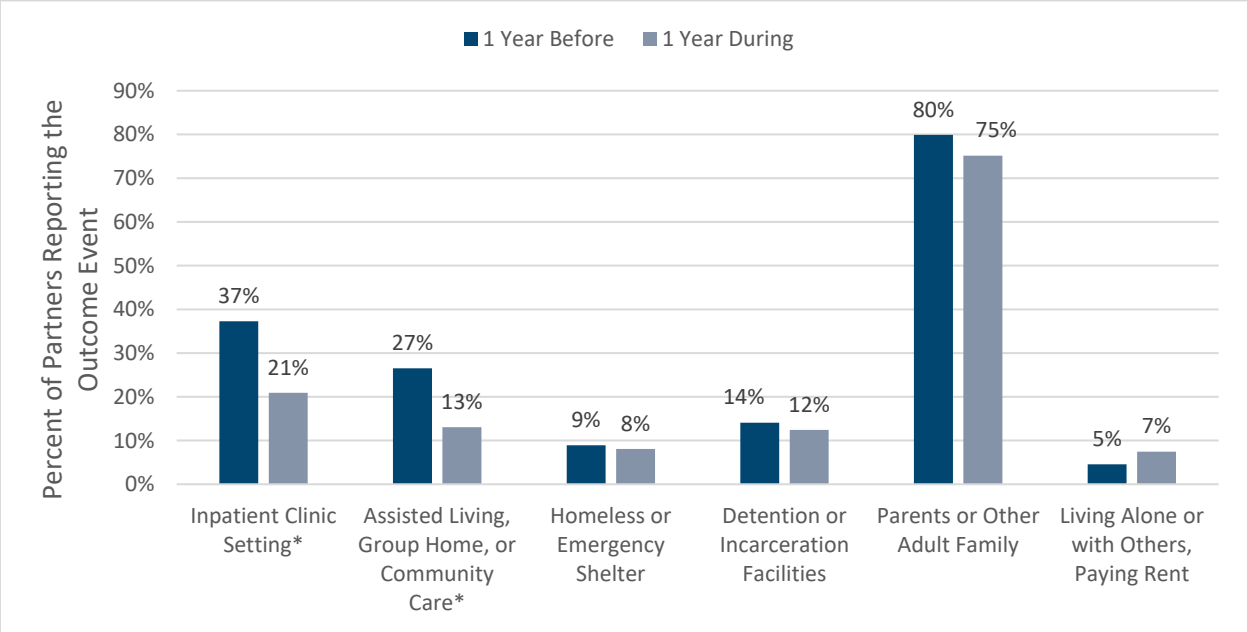
We used self-reported data from Caminar for Exhibit A1, data from Edgewood/Fred Finch for Exhibit A2, and data from Telecare for Exhibit A3. As shown in Exhibits A1–A3, the percentage of clients reporting any time in an inpatient clinic, homeless, incarcerated, or living with parents decreased. In contrast, for the percentage of clients who reported any time living alone or with others/paying rent increased or remained the same. Inconsistency across providers is observed for clients reporting any time in assisted living, group home, or community care environment, where the percentage for Caminar partners remained the same between the two consecutive years, the percentage for Edgewood/Fred Finch partners decreased, and the percentage for Telecare partners slightly increased. Asterisks in the exhibits denote outcomes that are statistically significant.

Exhibit A1. Percentage of Caminar Partners Completing 1 Year in the FSP Program Who Lived in a Residential Setting for Any Time During the Study Period (*N* = 192)



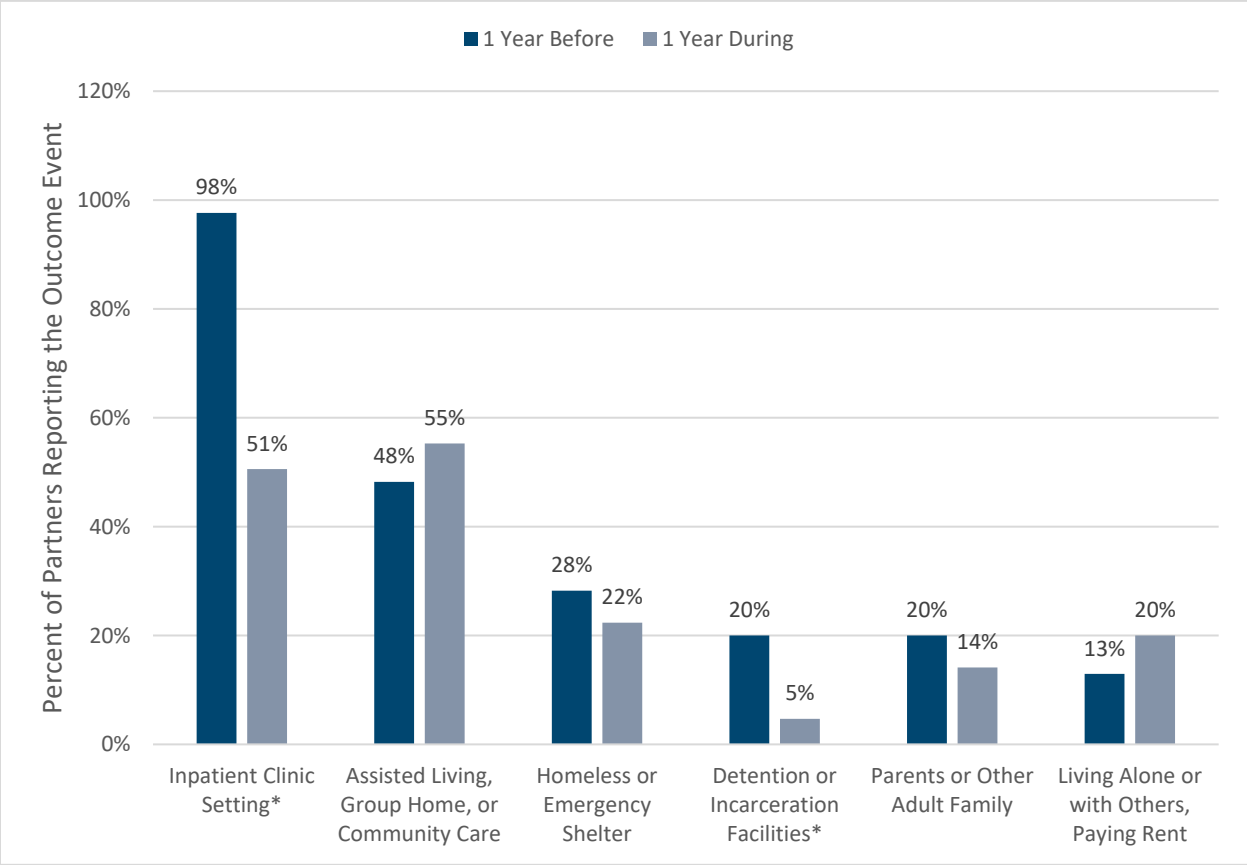
Note. Residential settings are not mutually exclusive, so percentages may exceed 100. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Exhibit A2. Percentage of Edgewood/Fred Finch Partners Completing 1 Year in the FSP Program Who Lived in a Residential Settings for Any Time During the Study Period (*N* = 483)



Note. Residential settings are not mutually exclusive, so percents may exceed 100. An outcome name with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Exhibit A3. Percentage of Telecare Partners Completing 1 Year in the FSP Program Who Lived in a Residential Settings for Any Time During the Study Period (*N* = 85)



Note. Residential settings are not mutually exclusive, so percentages may exceed 100. An outcome with * indicates that the change in that outcome is significantly different from 0 at 0.05 significance level.

Appendix B. Additional Detail on Outcomes by FSP Providers

This section provides outcomes by each provider.

Exhibits B1–B3 present the percentage of partners with any events the year just prior to full-service partnership (FSP) enrollment and the first year in an FSP, as well as the percent improvement for each FSP provider. Percent improvement is the change in percentage of partners who experienced the named event in the first year of FSP participation relative to the percentage of partners experiencing the event in the year prior to participating in an FSP.

As shown in Exhibit B1, there are improvements comparing the year prior to FSP to the first year during FSP for Caminar on all the available self-reported outcomes. Among these, outcomes on detention or incarceration, arrests, mental, and physical health emergencies are statistically significant.

Exhibit B1. Percentage of Caminar Partners With Outcome Events by Year and Percent Change in Prevalence of Outcome Events (Year Before FSP vs. the First Year of FSP Participation) (*N* = 192)

Survey outcomes, Caminar	1 year before	Year 1 during	Change (%)
Homelessness	38%	30%	-19%
Detention or incarceration	29%	16%	-46%*
Employment	1%	2%	300%
Arrests	21%	4%	-80%*
Mental health emergencies	72%	28%	-61%*
Physical health emergencies	40%	11%	-71%*
Active substance use disorder	49%	44%	-11%
Substance use disorder treatment	21%	23%	10%

Note. Blue font indicates outcomes that improved. Black font indicates outcomes did not change or changed but the change was not statistically significant. *Indicates a change significantly different from 0 at 0.05 significance level.

Exhibit B2 shows improvement for Edgewood Center and Fred Finch Youth Center (hereafter, Edgewood/Fred Finch) partners in all outcomes except for self-rated academic grade and school attendance. All but the outcomes on homelessness and detention or incarceration are statistically significant.

Exhibit B2. Percentage of Edgewood/Fred Finch Partners With Outcome Events by Year and Percent Change in Prevalence of Outcome Events (Year Before FSP vs. the First Year of FSP Participation) (*N* = 483)

Survey outcomes, Edgewood/Fred Finch	1 year before	Year 1 during	Change (%)
Homelessness	9%	8%	-9%
Detention or incarceration	14%	12%	-12%
Arrests	20%	6%	-68%*
Mental health emergencies	41%	7%	-82%*
Physical health emergencies	15%	1%	-92%*
Suspension	15%	5%	-63%*
Academic grade	3.31	3.06	-8%*
School attendance	2.28	2.13	-7%*

Note. Blue font indicates outcomes that improved. Red (and bold) font indicates outcomes that worsened. Black font indicates outcomes did not change or changed but the change was not statistically significant. *Indicates a change significantly different from 0 at 0.05 significance level.

As shown in Exhibit B3, there are improvements comparing the year prior to FSP to the first year during FSP for Telecare on four out of eight available self-reported outcomes. Worsened outcomes are observed for mental and physical health emergencies. Fewer partners reported receiving treatment for substance use disorder. However, we also see a decrease in reported active substance use, which may explain the decrease in reported treatment. The percent difference with employment is reported as N/A because the percentage of partners with employment did not change (from 0% to 0%). Thus, the denominator is 0. Outcomes on detention or incarceration, arrests, mental health emergencies, and active substance use disorder are statistically significant.

Exhibit B3. Percentage of Telecare Partners With Outcome Events by Year and Percent Change in Prevalence of Outcome Events (Year before FSP vs. the First Year of FSP Participation) (*N* = 85)

Survey outcomes, Telecare	1 year before	Year 1 during	Change (%)
Homelessness	28%	22%	-21%
Detention or incarceration	20%	5%	-76%*
Employment	0%	0%	N/A
Arrests	26%	9%	-64%*
Mental health emergencies	19%	36%	94%*
Physical health emergencies	13%	14%	9%
Active substance use disorder	58%	36%	-37%*
Substance use disorder treatment	8%	4%	-57%

Note. Blue font indicates outcomes that improved. Red (and bold) font indicates outcomes that worsened. Black font indicates outcomes did not change or changed but the change was not statistically significant. *Indicates a change significantly different from 0 at 0.05 significance level.

Appendix C. Methods

Methodology for Full-Service Partnership Survey Data Analysis

The full-service partnership (FSP) survey data are collected by providers through discussions with partners and should thus be viewed as self-reported outcomes. Among the providers included in these analyses (Edgewood Center and Fred Finch Youth Center [hereafter, Edgewood/Fred Finch], Caminar, and Telecare), 760 partners completed a Partner Assessment Form (PAF) at intake and completed a full year with FSP since program inception.

In general, three data sets are obtained for this report: one from Caminar, one from Telecare, and one from Edgewood/Fred Finch. All providers provide their data sets in a Microsoft Excel format. In 2018, Telecare changed their data system for the FSP survey in which the data structure and variable names were different from before. Because of data reliability issues, Telecare only provided the data after its data system change—that is, data from December 2018 onward. Therefore, the main analysis of this report includes all Caminar and Edgewood/Fred Finch partners, and a separate analysis is included for Telecare data since December 2018.

Edgewood/Fred Finch serve child partners and transitional age youth (TAY) partners. Caminar and Telecare serve primarily adult and older adult partners, and a small number of older TAY clients. Caminar's older TAY partners (*N* = 55) are excluded from the TAY-specific self-reported outcomes because Caminar does not reliably complete the ongoing program surveys (i.e., KET, 3M). Exhibit C1 describes the age group of partners completing at least 1 full year of FSP from 2006 to 2022 by provider. For Telecare, these data include December 2018 through June 2022.

Exhibit C1. Summary of Partners' 1 Full Year of FSP

Age group	Edgewood/ Fred Finch	Caminar	Telecare	Total[a]
Child (ages 16 and younger)	219	—	—	219
TAY (ages 17–25)	264	55	7	326
Adult (ages 26–59)	—	114	55	169
Older Adult (ages 60+)	—	23	23	46
Total	483	192	85	760

[a] Telecare partners in the analysis include only those who joined the FSP after December 1, 2018, due to data availability. Telecare partners were not reported in the survey outcomes by age group. A separate analysis was conducted for Telecare partners, it combines all age groups because of small sample size.

A master assessment file with FSP start and end dates and length of FSP tenure was created at the client level. Note that for clients who stopped and then reestablished their FSPs, we only kept the record corresponding with their most recent participation in an FSP (using Global ID), as indicated in the state's documentation.

Partner type (child, TAY, adult, and older adult) is determined by the partnership assessment form (PAF) data.

- For Caminar and Edgewood/Fred Finch, this was done by selecting records with specific Age Group codes, that is:
  - Caminar: Selected records with Age Group codes of "7" (TAY partner, ages 17 to 25), "4" (adult partner, ages 25 to 59), and "10" (older adult partner, ages 60 and older).
  - Edgewood/Fred Finch: Selected records with Age Group codes of "1" (child partner, ages 16 and younger) and "4" (TAY partner, ages 17 to 25).
  - In both cases, this was confirmed using the data file's continuous *Age* variable.
- For Telecare data, partners were given an age appropriate PAF. Records with specific *Form Type* codes were retained in the analysis (i.e., Form Types "TAY_PAF", "Adult_PAF", and "OA_PAF").

Partnership date and *end date* were determined as follows: Partnership date was determined using enrollment start date. End date was determined by the reported date of the partnership status change in the Key Event Tracking (KET) form to "discontinued." For clients still enrolled at the time of data acquisition, we assigned an end date of June 30, 2022.

All data management and analysis were conducted in Stata. All code is available upon request.

Additional details on the methodology for each outcome are presented below.

Residential Setting

1. Residential settings were grouped into categories as described in Exhibit C2.
2. The baseline data were populated using the variable *PastTwelveDays* (Caminar and Edgewood/Fred Finch) or *res_past12m_days_int* (Telecare) collected by the PAF. Individuals without any reported locations were assigned to the "Don't Know" category.
3. The partner's first residential status after they joined FSP is determined by the *Current* (Caminar and Edgewood/Fred Finch) or *res_curr_dsr* (Telecare), collected by the PAF. Individuals without any reported current residence were assigned to the "Don't Know" category. Some individuals had more than one first residence location. In this case, if there was one residence with a later date (as indicated by the variable *DateResidentialChange* [Caminar and Edgewood/Fred Finch] or *main_resident_date* [Telecare]), this residence was considered to be the first residential setting. If the residences were marked with the same date, both were considered as part of the partner's first year in an FSP.
4. Additional residential settings for the first year were found using the key event tracking (KET) data, inclusive of all residence types listed with a corresponding date of residential change (*DateResidentialChange* [Caminar and Edgewood/Fred Finch] or *main_resident_date* [Telecare]) occurring within 1 year of the FSP partnership start date. If no residential data were captured subsequent to the PAF by a KET, it was assumed that the individual remained in their original residential setting.

Exhibit C2. Residential Setting Categories and Corresponding Classification Values Used to Derive Them

Category	Telecare, Caminar, Edgewood/Fred Finch setting value[a]
With family or parents	
With parents	1
With other family	2
Alone	
Apartment alone or with spouse	3
Single occupancy (must hold lease)	19
Foster home	
Foster home with relative	4
Foster home with nonrelative	5
Homeless or emergency shelter	

Category	Telecare, Caminar, Edgewood/Fred Finch setting value[a]
Emergency shelter	6
Homeless	7
Assisted living, group home, or community care	
Individual placement	20
Assisted living facility	28
Congregate placement	21
Community care	22
Group home (Level 0–11)	11
Group home (Level 12–14)	12
Community treatment	13
Residential treatment	14
Inpatient facility	
Acute medical	8
Psychiatric hospital (other than state)	9
Psychiatric hospital (state)	10
Nursing facility, physical	23
Nursing facility, psychiatric	24
Long-term care	25
Incarcerated	
Juvenile hall	15
Division of Juvenile Justice	16
Jail	27
Prison	26
Other / Don't know	
Don't know	18
Other	17

[a] Setting names determined by the following guide: https://mhdatapublic.blob.core.windows.net/fsp/DCR%20Data%20Dictionary_2011-09-15.pdf

Employment

Employment outcomes were generated for adults only. Therefore, Edgewood/Fred Finch data were excluded.

1. The baseline data were populated using the PAF data. An individual was considered as having had any employment if there was a nonzero, nonblank value for one of the following variables (note that variable names differ slightly by data set):
    a. Any competitive employment in the past 12 months (any competitive employment; any competitive employment for any average number of hours per week; any average wage for competitive employment)
    b. Any other employment in the past 12 months (any other employment; any other employment for any average number of hours per week; any average wage for any other employment)
2. Ongoing employment was populated using any dates of employment change (variable names vary slightly by file) noted in the KET file within the first year of membership in an FSP (as determined by the partnership start date). An employment change was coded if the new employment status code corresponding to the employment change date indicated competitive employment or other employment. If the KET contained no information on employment, the original employment was presumed to sustain throughout FSP membership.

Arrests

1. The baseline arrest data were populated using the variable *ArrestsPast12* (Caminar and Edgewood/Fred Finch) or *lgl_arrest_p12_times* (Telecare) collected by the PAF. If the variable was blank, the partner was assumed to have zero arrests in the year prior to FSP.
2. Ongoing arrests were populated using any dates of arrest (variable names vary slightly by file) noted in the KET file within the first year of membership in FSP (as determined by the partnership date). If the KET contained no information on arrests, the partner was assumed to have had no arrests in the first year in an FSP.

Mental and Physical Health Emergencies

1. The baseline utilization of emergency services was populated using the PAF's variables for mental health emergencies (*MenRelated* [Caminar and Edgewood/Fred Finch] or *emr_mental_p12* [Telecare]) and physical health emergencies (*PhysRelated* [Caminar and Edgewood/Fred Finch] or *emr_physical_p12* [Telecare]), respectively. If either of these fields were blank, the partner was assumed to have had zero emergencies of that type in the year prior to FSP.
2. Ongoing emergencies were populated using the variable indicating the date of emergency (variable names vary slightly by file) in the KET file, as long as the date is within the first year with an FSP as determined by the partnership date. The type of emergency was indicated by *EmergencyType* (Caminar and Edgewood/Fred Finch) or *main_emergency_int_dsr* (Telecare) ("1" = physical; "2" = mental). We assumed that no information on emergencies in the KET indicated that no emergencies had occurred in the first year of an FSP.

Substance Use Disorder

1. Baseline data on substance use disorder were populated using variables in the PAF for active substance use disorder (*ActiveProblem* [Caminar and Edgewood/Fred Finch] or *sub_co_mh_sa_probl_past* [Telecare]) and participation in substance use disorder treatment and recovery services (*AbuseServices* [Caminar and Edgewood/Fred Finch] or *sub_sa_services_now* [Telecare]). If these fields were blank, the partner was assumed to have had no substance use disorder nor received substance use disorder treatment and recovery services in the year prior to FSP.
2. Ongoing substance use disorder data were populated using the 3-month data variables of the same name. Any record of an active substance use disorder or participation in a substance use disorder treatment during the first year of FSP was recorded. If there were no observations in the variables of interest, clients were assumed to have no ongoing substance use disorder or participation in substance use disorder treatment.

Methodology for County EHR Data Analysis

Hospitalization outcomes were derived from electronic health records (EHR) data obtained through the Avatar system. Using EHR data avoids some of the reliability shortcomings of self-reported information but presents several challenges as well. The Avatar system is limited to individuals who obtain emergency care in the San Mateo County (the County) hospital system. Hospitalizations outside of the County, or in private hospitals, are not captured. The hospitalization outcomes include 854 partners who were both (a) included in the County's EHR system and (b) completed 1 full year or more in an FSP program by the June 2022 data

acquisition date. Thus, individuals included in the EHR analysis had to have started with the FSP between July 2006 (the program's inception) and June 2021.

All data management and analysis were conducted in Stata. Code is available upon request.

To count instances of psychiatric hospitalizations and psychiatric emergency services (PES) admissions, we relied on the Avatar *view_episode_summary_admit* table. Exhibit C3 shows the corresponding program codes. In addition, FSP episodes were identified through the Avatar *episode_history* table.

Exhibit C3. Program Codes Among Clients Ever in an FSP

Program code	Program value
Psychiatric hospitalizations	
410200	ZZ410200 PENINSULA HOSPITAL INPT-MSO I/A
410205	410205 PENINSULA HOSPITAL INPATIENT
410700	410700 SMMC INPATIENT
921005	921005 NONCONTRACT INPATIENT
926605	926605 JOHN MUIR MED. CTR INPT MAN CARE
Psychiatric emergency services	
410702	Z410702 SMMC PES-termed 10/31/14
410703	410703 PRE CONV SMMC PES~INACTIVE
41CZ00	41CZ00 SAN MATEO MEDICAL CENTER - PES

Note. Data represent all utilization from FSP clients for these codes, as pulled from Avatar on October 25, 2022.

Partner type (child, TAY, adult, and older adult) was determined by the partner's age on the start date of the FSP program, as derived from the *c_date_of_birth* variable from the *view_episode_summary_admit* table and the *FSP_admit_dt* variable from the *episode_history* table.

As we have discussed in the previous year's report, the distribution of partners by age group is different between the County's EHR data and the FSP survey data. This is likely because of the different ways age group was determined. For the survey data, AIR determined age group by whether the partner was evaluated using the child, TAY, adult, or older adult FSP survey forms. For the County's EHR data, AIR assigned individuals to an age group based upon the date they joined FSP and their reported date of birth.

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APPENDIX 9. OUTREACH COLLABORATIVES REPORT, FY 2021-22

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Annual Report

FY 2021–2022

Koray Caglayan, PhD, Danielle Agraviador, MPH

December 2022

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Executive Summary

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), which provides funding to counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. The Community Services and Supports (CSS) component of MHSA was created to provide direct services to individuals with severe mental illness and includes Outreach and Engagement activities.

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) funds the North County Outreach Collaborative (NCOC) and the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO). Each of these organizations provide outreach and engagement activities throughout San Mateo County. Each collaborative also has providers who provide direct services to the populations they serve.

This report summarizes self-reported data from attendees at individual and group outreach events that occurred in fiscal year (FY) 2021–2022 (July 1, 2021, through June 30, 2022). We also present historical data since FY 2014–2015 to show how attendance has changed over time. The appendices provide the same information at the provider level.

Total Attendance

For FY 2021–2022, SMC BHRS providers reported that there were 7,961 attendees at all outreach events, which reflects a 6.2% increase in total attendance compared with FY 2020–2021 (which saw 7,499 attendees). The attendance at individual outreach events increased by 302 attendees in FY 2021–2022 compared with FY 2020–2021. During FY 2021–2022, SMC providers reached 7,144 attendees across 174 group outreach events, while during FY 2020–2021, providers reached 6,984 attendees across 115 group outreach events.

Demographic Characteristics of Outreach Attendees

NCOC

There were 7,577 attendees at NCOC outreach events. Among attendees at NCOC outreach events, the most common age group was children (29%). Almost half of the attendees were female (47%). The three largest racial/ethnic groups were White (30%), Filipino (9%), or Other race (9%). Seventeen percent of attendees declined to state their race or ethnicity. Of those reporting special population status (i.e., homeless, at risk for homelessness, vision impaired, hearing impaired, veterans), 33% of attendees reported being at risk for homelessness, and 15% of attendees reported being homeless.

EPAPMHO

There were 384 attendees at EPAPMHO outreach events. Most attendees were adults (76%) and females (57%). The greatest proportion of attendees by race/ethnicity were Mexican (49%), followed by Black (11%). Of those reporting special population status, 38% were at risk for being homeless and 21% were homeless.

Outreach Event Characteristics

NCOC

NCOC individual outreach events ranged from 5 minutes to 2.5 hours and averaged 35 minutes. Outreach events took place in schools (32%) and over the phone (28%). Almost all individual outreach events were conducted in English (99.5%).

NCOC group outreach events ranged from 5 minutes to 6.2 hours and averaged 75 minutes. Of the 173 group outreach events, most were conducted in schools (54%) or virtually (28%). Most group outreach events were conducted in English (95%), followed by Spanish (5%).

NCOC individual outreach events resulted in mental health referrals (21%) and substance use referrals (4%). Providers made 1,081 referrals for 443 NCOC individual outreach attendees. The top four types of referrals made for attendees were in medical care (22%), food (16%), financial services (10%), and cultural, nontraditional care (10%).

EPAPMHO

EPAPMHO individual outreach events lasted from 10 to 30 minutes and averaged 16 minutes. Most outreach events took place over the phone (50%) or in offices (32%). More than half were held in Spanish (59%).

There was one EPAPMHO group outreach event that lasted 30 minutes. This event occurred in an office and was conducted in Tongan.

EPAPMHO individual outreach events resulted in mental health referrals (26%) and substance use referrals (37%). Providers made 627 referrals for 374 attendees. The top three types of referrals were for medical care (28%), housing (26%), and form assistance (11%).

Recommendations

We have the following recommendations based on FY 2021–2022 data. These recommendations fall under two umbrellas: those aimed at enhancing outreach and those intended to improve data collection.

Enhance Outreach

Providing outreach in different languages and offering non-office visits and virtual appointments may have resulted in modest increases in the number of participants attending outreach events this year.

Continue to conduct outreach in languages other than English. This past reporting year, outreach events were conducted in languages that represented the residents served by the participating providers. For example, the EPAPMHO collaborative conducted outreach in Spanish, as the Mexican population was the largest racial/ethnic population attending these events. Similarly, other EPAPMHO individual outreach events were offered in Tongan and Samoan, as participants indicated that these languages were their preferred languages. Conducting outreach in languages other than English can ensure that the SMC BHRS outreach program is serving the needs of the county's non-English-speaking population.

Continue to offer non-office locations for group and individual outreach events. Data shows that many outreach events were conducted in communities and in nontraditional locations such as over the phone and through telehealth services. Although this may have been in response to the COVID-19 pandemic, the county should consider continuing to provide alternative locations or venues, including a virtual option. This will give county residents multiple options to avail themselves of the services offered through the program.

Provide social service referrals to attendees at group outreach events as well. The county provides referrals to social services like housing and form assistance to those who attend individual outreach events. The county could consider offering similar referrals to social services during group outreach events as this will help to address attendees' needs and help improve their overall health and well-being.

Introduction

In 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), which provides funding to counties for mental health services by imposing a 1% tax on personal income in excess of $1 million. Activities funded by MHSA are grouped into various components. The Community Services and Supports (CSS) component was created to provide direct services to individuals with severe mental illness. CSS is allotted 80% of MHSA funding for services focused on recovery and resilience while providing clients and families with an integrated service experience. CSS has three service categories: (1) Full-Service Partnerships, (2) General Systems Development Funds, and (3) Outreach and Engagement.

The San Mateo County Behavioral Health and Recovery Service (SMC BHRS) MHSA Outreach and Engagement strategy aims to increase access and improve linkages to behavioral health services for underserved communities. Strategies include community outreach collaboratives, pre-crisis response, and primary care-based efforts. SMC BHRS has seen a consistent increase in the representation of underserved communities in its system since the strategies were deployed.

Community outreach collaboratives funded by MHSA include the East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) and the North County Outreach Collaborative (NCOC). EPAPMHO caters to transition-age youth and underserved adults; Latino, African American, and Pacific Islander communities; and people who identify as lesbian, gay, bisexual, transgender, and questioning (LGBTQ) in East Palo Alto. NCOC caters to rural and/or ethnic communities (Chinese, Filipino, Latino, Pacific Islander) and LGBTQ communities in the North County region, including Pacifica. These collaboratives provide advocacy, systems change, resident engagement, expansion of local resources, and education and outreach to decrease stigma related to mental illness and substance use. They work to increase awareness of, and access and linkages to, culturally and linguistically competent services for behavioral health, Medi-Cal and other public health services, and social services. They participate in a referral process to ensure that those in need receive appropriate services such as food, housing, and medical care. Finally, they promote and facilitate resident input into the development of MHSA-funded services and other BHRS program initiatives.

The American Institutes for Research (AIR) has supported SMC BHRS in providing findings from the county's outreach activities since fiscal year (FY) 2014–2015. This annual report provides details on outreach activities conducted by providers in FY 2021–2022 (July 1, 2021, through June 30, 2022). Providers collected outreach data using an electronic form (SurveyMonkey®) that gathers self-reported information from attendees. AIR created this form based on interviews with San Mateo County staff and focus groups with providers. After data are entered, AIR cleans the data and calculates aggregated counts and percentages to describe outreach activities.

This report focuses on EPAPMHO and NCOC outreach events that occurred during FY 2021–2022. We also present historical data from FY 2014–2015, FY 2015–2016, FY 2016–2017, FY 2017–2018, FY 2019–2020, FY 2020–2021, and FY 2021–2022 to show how outreach has changed over time. Counts of attendees do not necessarily represent unique individuals because a person may have been part of more than one outreach event, taken part in both individual and group outreach events, and/or interacted with different providers. Summaries are also available to help SMC BHRS and its providers enhance their understanding of each individual provider's outreach efforts. Please refer to Appendices A–H for provider-specific summaries.

Overall Outreach

During FY 2021–2022, SMC BHRS outreach providers reported that there were 7,961 attendees at outreach events—817 attendees reached through individual outreach events and 7,144 attendees reached across 174 group outreach events. An individual outreach event include a single attendee, while group outreach events include multiple attendees. As stated earlier in this document, the count of attendees is not necessarily unique because a person may have been a part of multiple individual or group outreach events.

Exhibit 1 shows the number of outreach attendees by collaborative, provider, and event type (i.e., individual or group), for FY 2021–2022.

Exhibit 1. Outreach Attendees, by Collaborative, Provider, and Event Type, FY 2021–2022

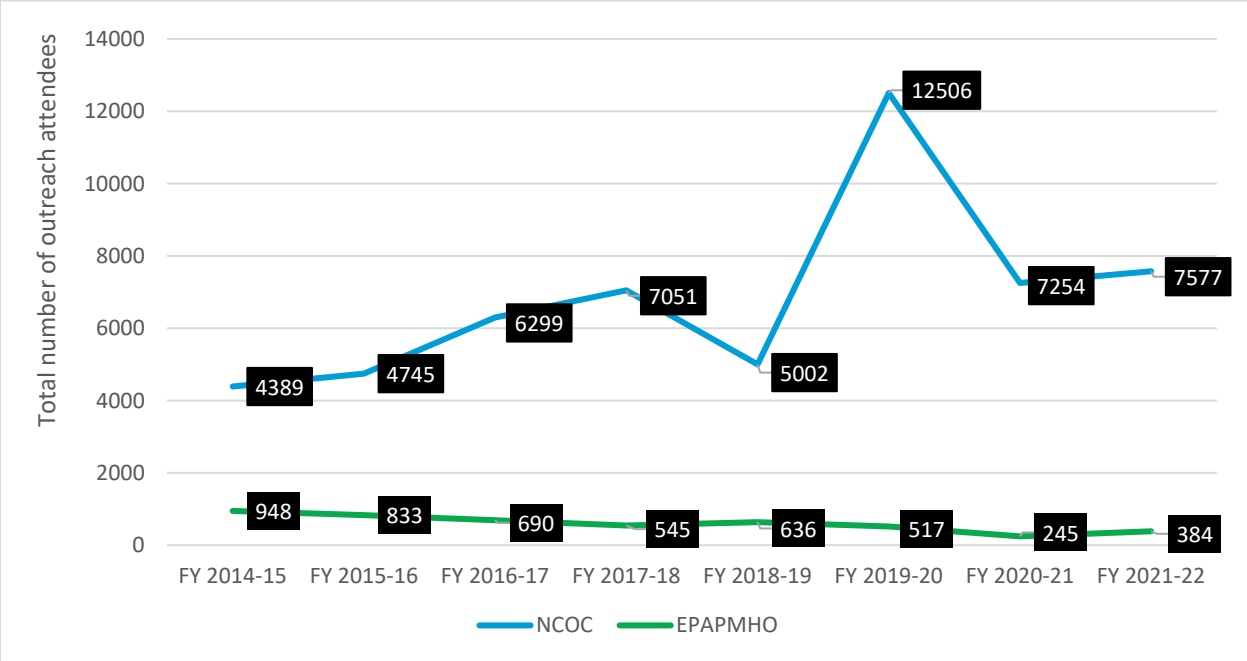
Provider organization	Number of individual outreach attendees	Number of attendees at group outreach events	Total attendees reported across all events
North County Outreach Collaborative (NCOC)			
Asian American Recovery Services	191	356	547
Daly City Peninsula Partnership Collaborative	110	748	858
Daly City Youth Health Center	128	2,797	2,925
Pacifica Collaborative	14	3,207	3,221
Star Vista	0	26	26
Total (NCOC)	443	7,134	7,577
East Palo Alto Partnership for Mental Health Outreach (EPAPMHO)			
Anamatangi Polynesian Voices	54	10	64
El Concilio	149	0	149
Free At Last	171	0	171
Total (EPAPMHO)	374	10	384
Total (NCOC and EPAPMHO)	817	7144	7961

Note. EPAPMHO = East Palo Alto Partnership for Mental Health Outreach; NCOC = North County Outreach Collaborative. Multicultural Counseling and Education Services of the Bay Area (MCES) changed its name to Anamatangi Polynesian voices.

The NCOC is expected to serve a larger proportion of the outreach collaborative effort, as NCOC serves the entire northern region of San Mateo County (estimated population = 139,919), including the cities of Colma, Daly City, and Pacifica. The population of these cities is five times the population of the city of East Palo Alto, which is served by EPAPMHO. The north region also spans a much wider geographical area, making group events (vs. individual outreach) such as community-wide fairs more feasible. In contrast, East Palo Alto spans 2.5 square miles, making an individual approach to outreach more achievable.

The Number of individual outreach attendees number of NCOC outreach attendees increased annually from 2014 to 2020, with the exception of FY 2018–2019. In 2019–2020, the number of NCOC attendees increased significantly due to the COVID-19 pandemic. The COVID-19 regional stay-at-home order was issued on March 16, 2020, and services provided from March to June 2020 showed an increase in outreach, as many more residents were likely seeking mental health services in response to the pandemic. Events sponsored by the Daly City Peninsula Partnership Collaborative and the Daly City Youth Health Center also addressed food security during the pandemic (FY 2019–2020) by distributing food during the events. A higher attendance at these events may contribute to an overall increase seen in FY 2019–2020. The number of EPAPMHO outreach attendees decreased from FY 2014 to FY 2021 but increased from FY 2020–2021 to FY 2021–2022. **Exhibit 2** shows the trends in the number of outreach attendees over the years for both collaboratives.

Exhibit 2. Total Outreach Attendees, by Collaborative, FY 2014–2022



Note. The number of attendees from previous fiscal years is slightly higher than the number reported in the previous reports because some outreach data were reported after that fiscal year.

Exhibits 3a and 3b present the top five racial/ethnic groups served by individual or group outreach in each year for the past 5 fiscal years (i.e., FY 2017–2018, FY 2018–2019, FY 2019–2020, FY 2020–2021, and FY 2021–2022), within each collaborative. A table with the entire breakdown of racial/ethnic groups from FY 2017 to FY 2022 is presented in Appendix I.

Exhibit 3a. Percentage of Racial/Ethnic Groups Served by NCOC, FY 2017–2018 to FY 2021–2022

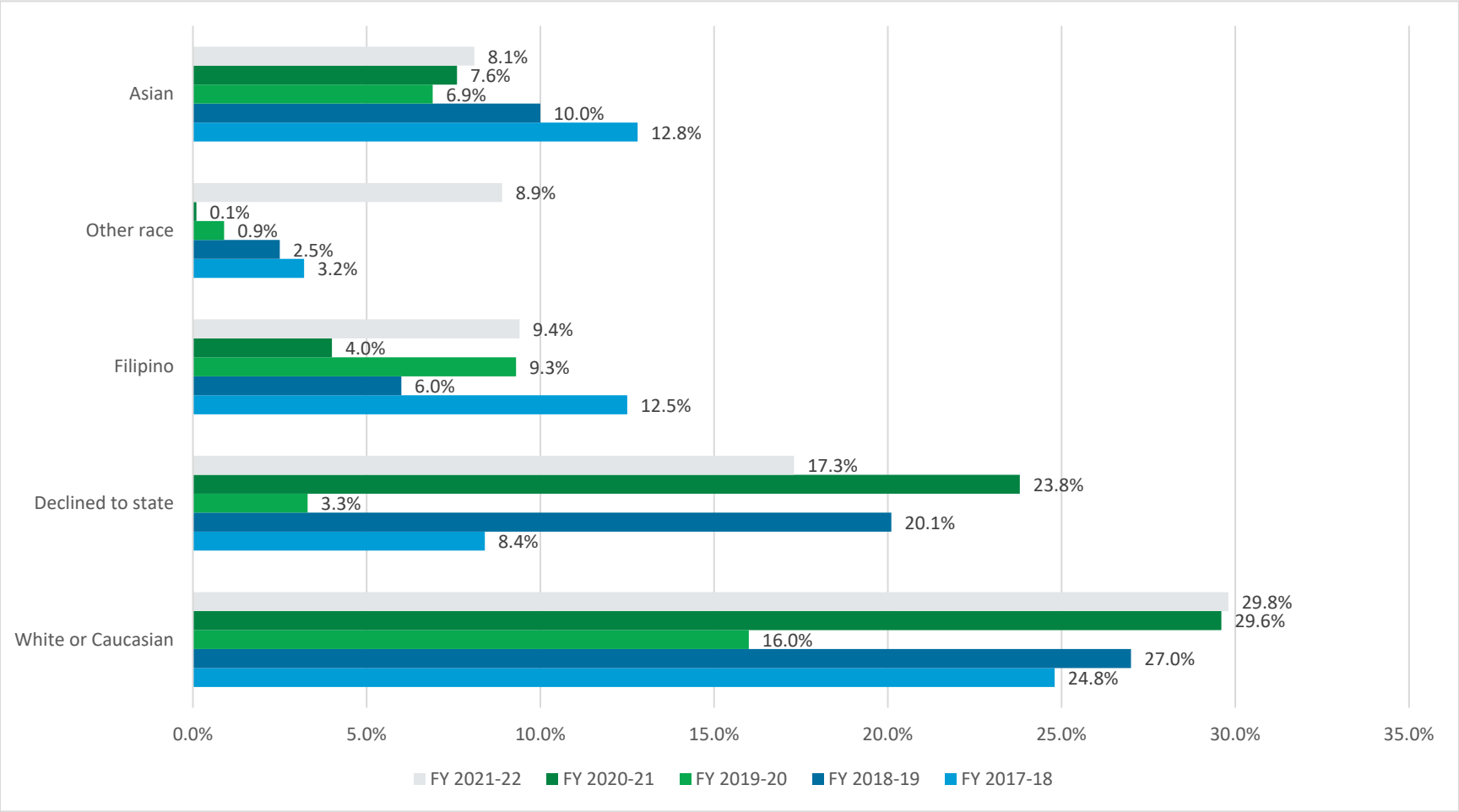
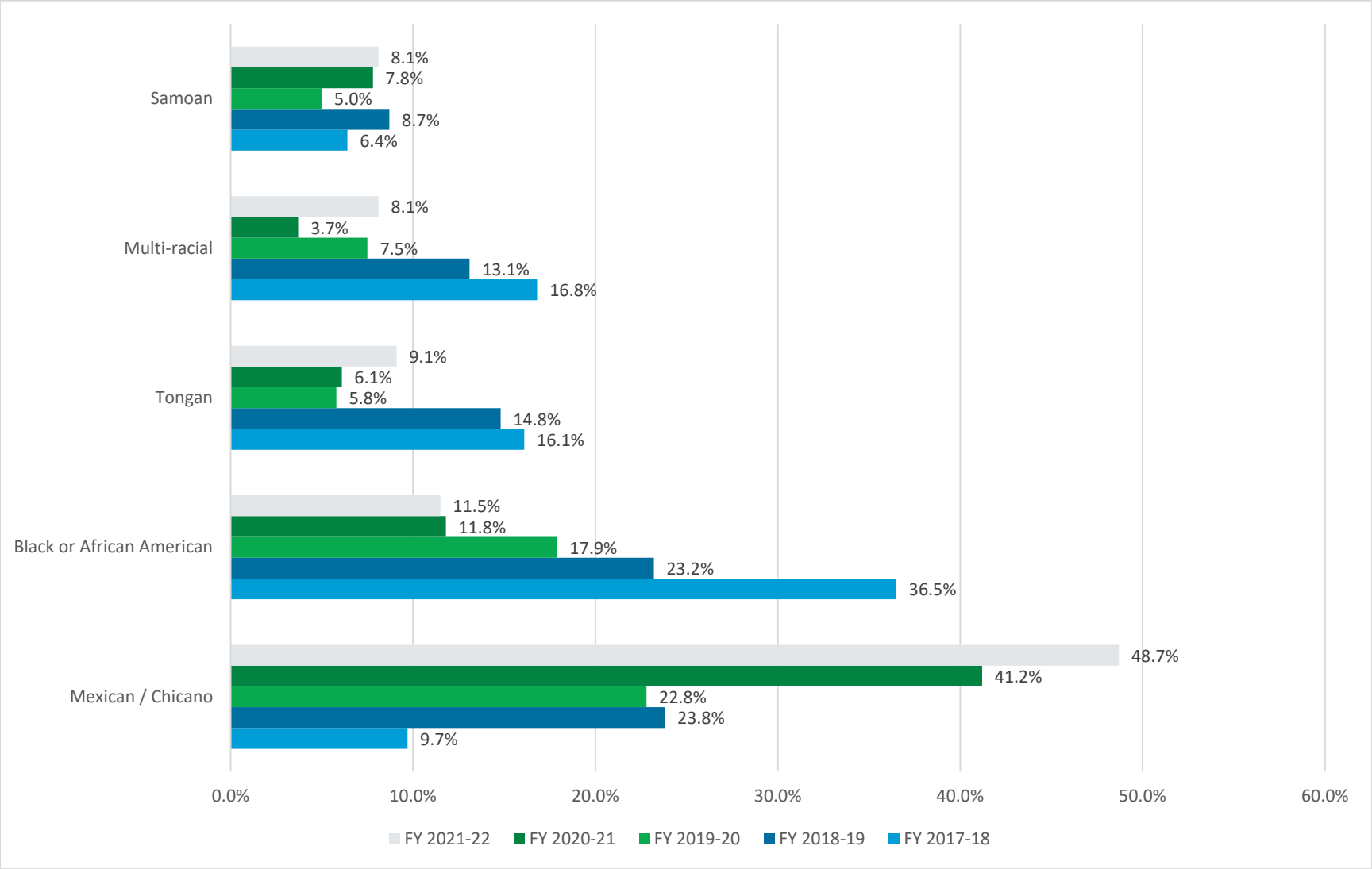


Exhibit 3b. Percentage of Racial/Ethnic Groups Served by EPAPMHO, FY 2017–2018 to FY 2021–2022



The NCOC has seen an increase in outreach numbers this year compared to FY2020–2021 (see **Exhibit 2**), and there are a few key differences in the racial/ethnic demographics of the outreach attendees. For example, more attendees decided to state their race/ethnicity this year compared with FY 2020–2021. Therefore, we see a decrease in those declining to state their race/ethnicity and an increase in the attendees specifying a particular race.

The EPAPMHO has also seen an increase in outreach numbers this year compared with FY 2020–2021 (see **Exhibit 2**), and there are a few key differences in the racial/ethnic demographics of the outreach attendees. From FY 2020–2021 to FY 2021–2022, there has been an observed decrease in attendance by Black and multiracial attendees at these events. However, there has been an increase in attendees self-reporting their race/ethnicity as Mexican, Tongan, multiracial, and Samoan.

Exhibit 4a presents the percentages of mental health and substance use referrals by NCOC from FY 2017–2018 through FY 2021–2022. Compared with FY 2020–2021, the number of mental health referrals decreased by 29% in FY 2021–2022 and reached levels similar to those seen before the COVID-19 pandemic. The number of substance use referrals also declined during this time frame.

Exhibit 4a. Percentage of Mental Health/Substance Use Referrals by NCOC, FY 2017–2018 to FY 2021–2022

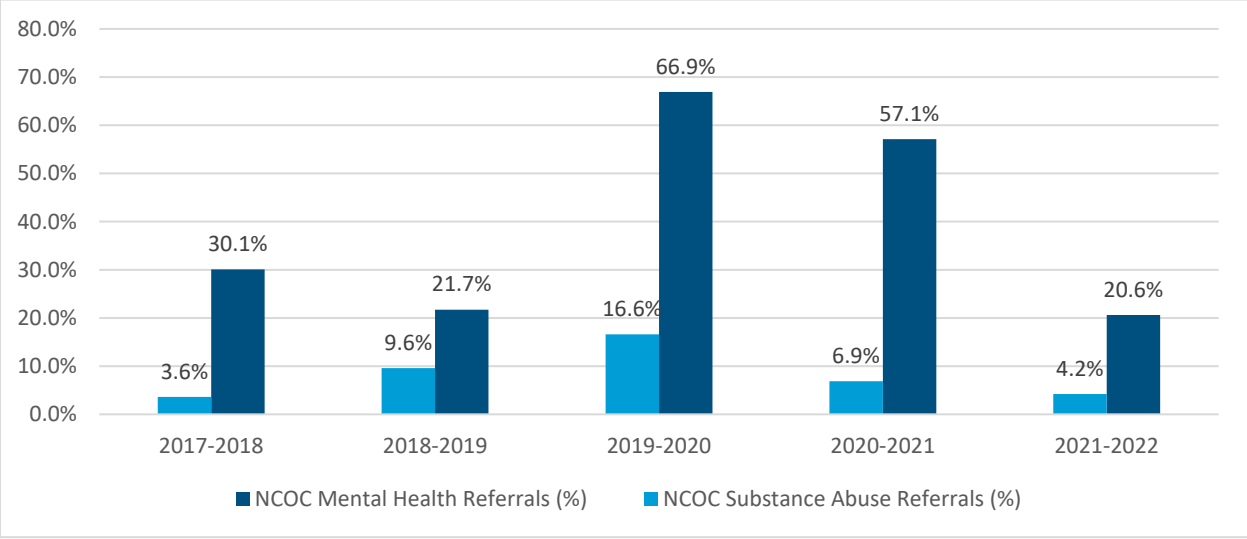
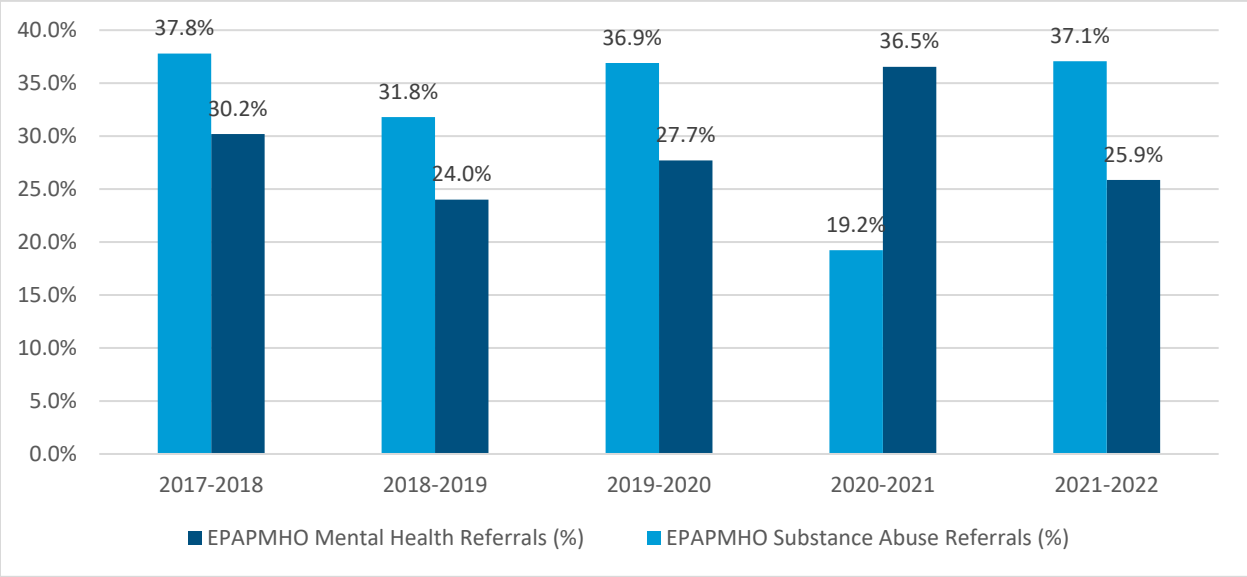


Exhibit 4b presents the percentages of mental health and substance use referrals by EPAPMHO from FY 2017–2018 through FY 2021–2022. Compared with FY 2020–2021, the number of mental health referrals decreased by 10.6% this year. The number of substance use referrals increased during this time frame.

Exhibit 4b. Percentage of Mental Health/Substance Use Referrals by EPAPMHO, FY 2017–2018 to FY 2021–2022



Exhibits 5a and 5b present referrals to social services from FY 2017–2018 through FY 2021–2022 for each collaborative. The percentages represent the percentage of total attendee referrals to social services.

- NCOC had 1,081 referrals to social services in FY 2021–2022 compared with 866 referrals in FY 2020–2021, 1,101 referrals in FY 2019–2020, 330 referrals in FY 2018–2019, and 592 referrals in FY 2017–2018. In FY 2020–2021, EPAPMHO had 627 referrals to social services compared with 367 referrals in FY 2020–2021, 563 referrals in FY 2019–2020, 921 referrals in FY 2018–2019, and 727 referrals in FY 2017–2018.
- In FY 2021–2022, NCOC saw decreases in food, legal, and housing assistance compared with the prior year. In particular, the referrals for housing were the lowest seen since FY 2017–2018. On the other hand, the percentage of referrals to medical care, financial assistance, and cultural, nontraditional care increased in FY 2021–2022 compared with the previous year, indicating that residents continued to face challenges pertaining to health, employment, and cultural, nontraditional forms of care.
- In FY 2021–2022, EPAPMHO had decreases in the percentage of referrals for form, legal, food, and health insurance assistance. The percentage of referrals for medical care and housing assistance increased.

Exhibit 5a. Referrals to Social Services Made by NCOC, FY 2017–2018 to FY 2021–2022

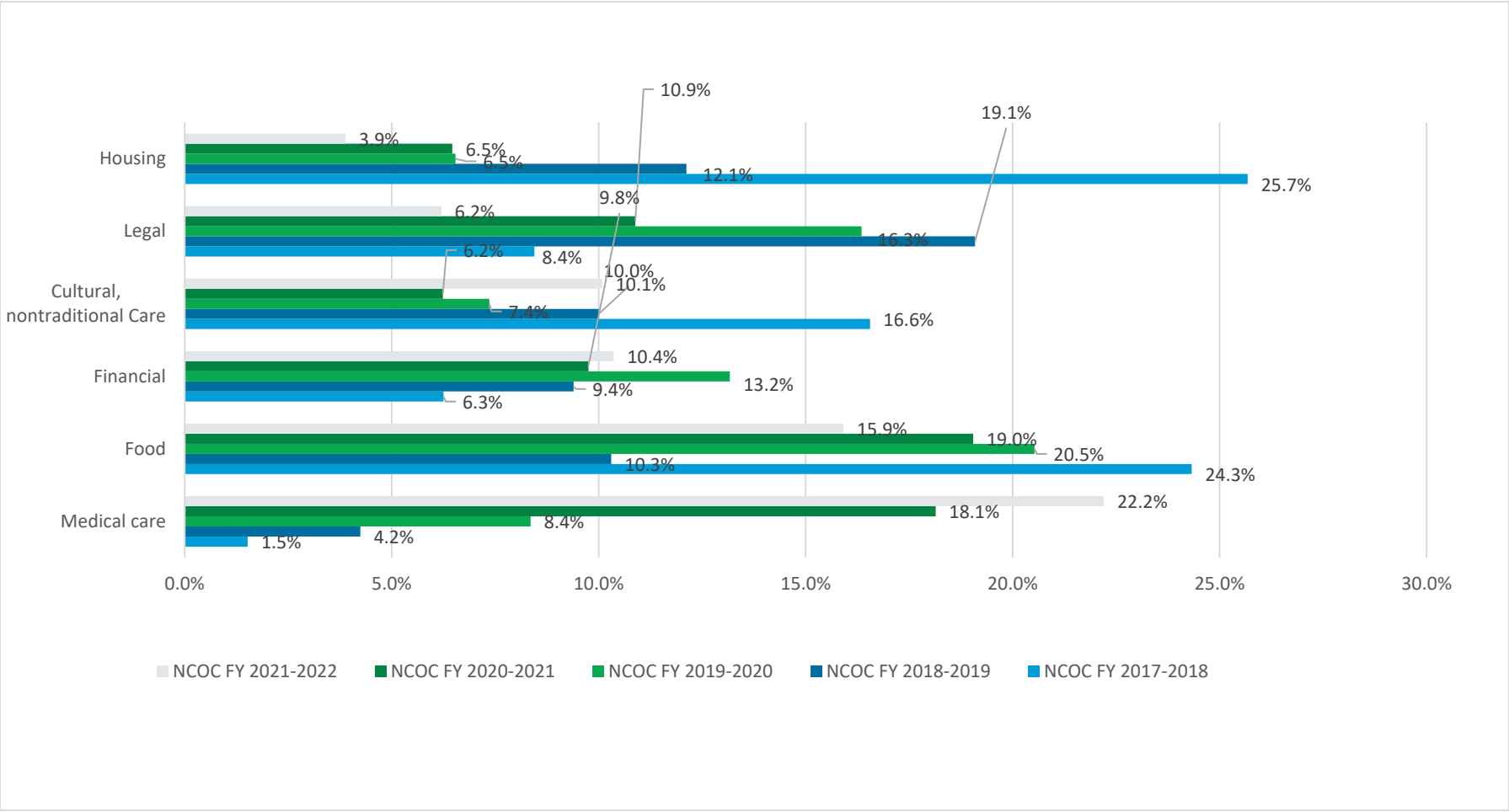
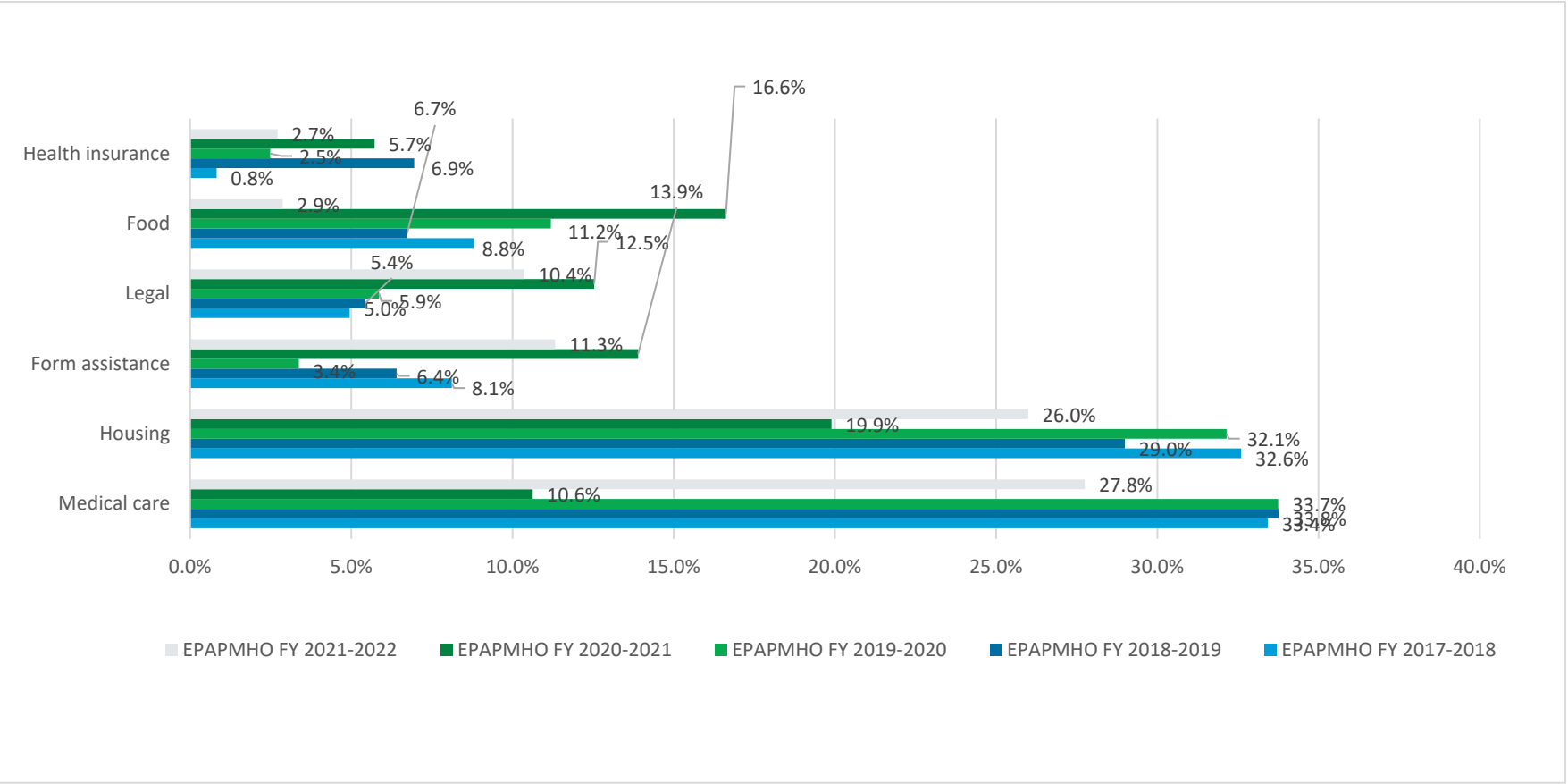


Exhibit 5b. Referrals to Social Services Made by EPAPMHO, FY 2017–2018 to FY 2021–2022



The following sections provide details about the attendees at group and individual outreach events across the two collaboratives and their respective provider organizations.

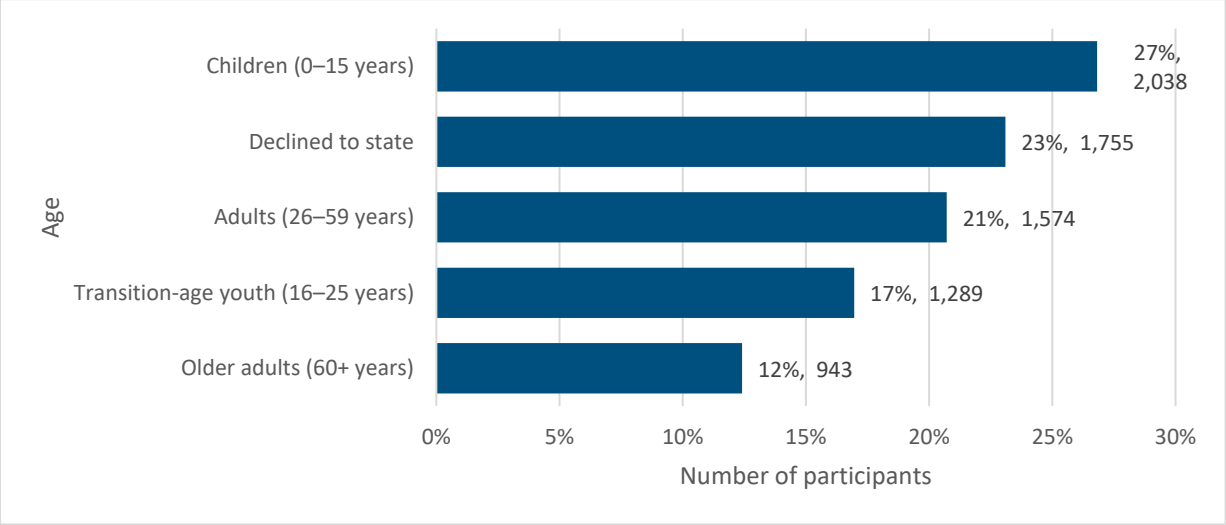
NCOC

This section provides details about 7,577 attendees at NCOC group and individual outreach events across the five provider organizations in FY 2021–2022.

Demographics

Age: Attendees across NCOC outreach events were children (0–15 years of age; 27%), adults (26–59 years of age; 21%), transition-age youth (16–25 years of age; 17%), and older adults (60 years of age and older; 12%) in FY 2021–2022. Twenty-three percent of attendees declined to state their age. See **Exhibit 6** for the number and percentage of total outreach attendees representing each reported age group.

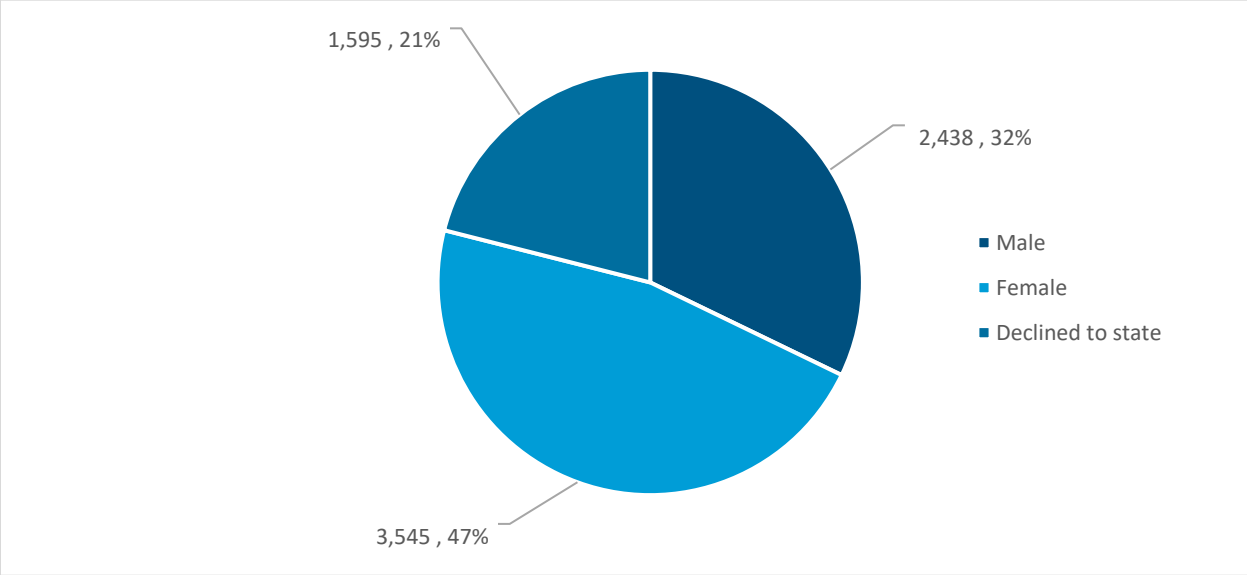
Exhibit 6. Age of Total Outreach Attendees Served by NCOC, FY 2021–2022



Note. Percentages may not sum to 100% because of rounding. The denominator for age percentage is the sum of all age data reported. The total count for age reported may exceed the total number of attendees because some providers may have reported individuals in two or more age groups, leading to extra counts in some cases for the group outreach attendees. The denominator for age percentage is the sum of all age data reported.

Sex at birth: Exhibit 7 shows the sex at birth of attendees across NCOC group and individual outreach events for FY 2021–22. Attendees indicated their sex at birth as female (47%), male (32%), or they declined to state their sex at birth.

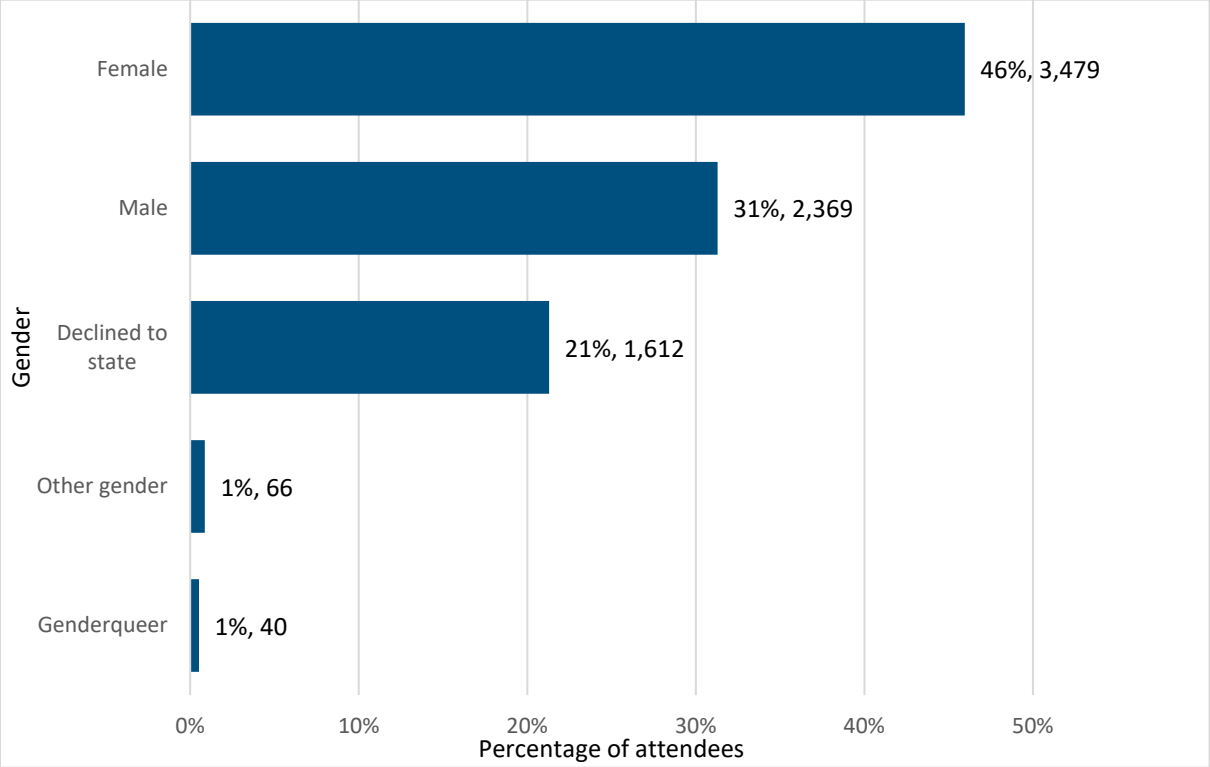
Exhibit 7. Sex at Birth of Outreach Attendees Served By NCOC, FY 2021–2022



Note. Percentages may not sum to 100% because of rounding. The total count for sex reported may exceed the total number of attendees because some providers may have reported individuals in two or more sex groups, leading to extra counts in some cases for the group outreach attendees. The denominator for sex percentage is the sum of all sex data reported.

Gender: Exhibit 8 shows the gender of attendees across NCOC group and individual outreach events for FY 2021–22. Attendees identified themselves as female (46%), male (31%), other gender (1%), or genderqueer (1%). Twenty-one percent declined to state their gender.

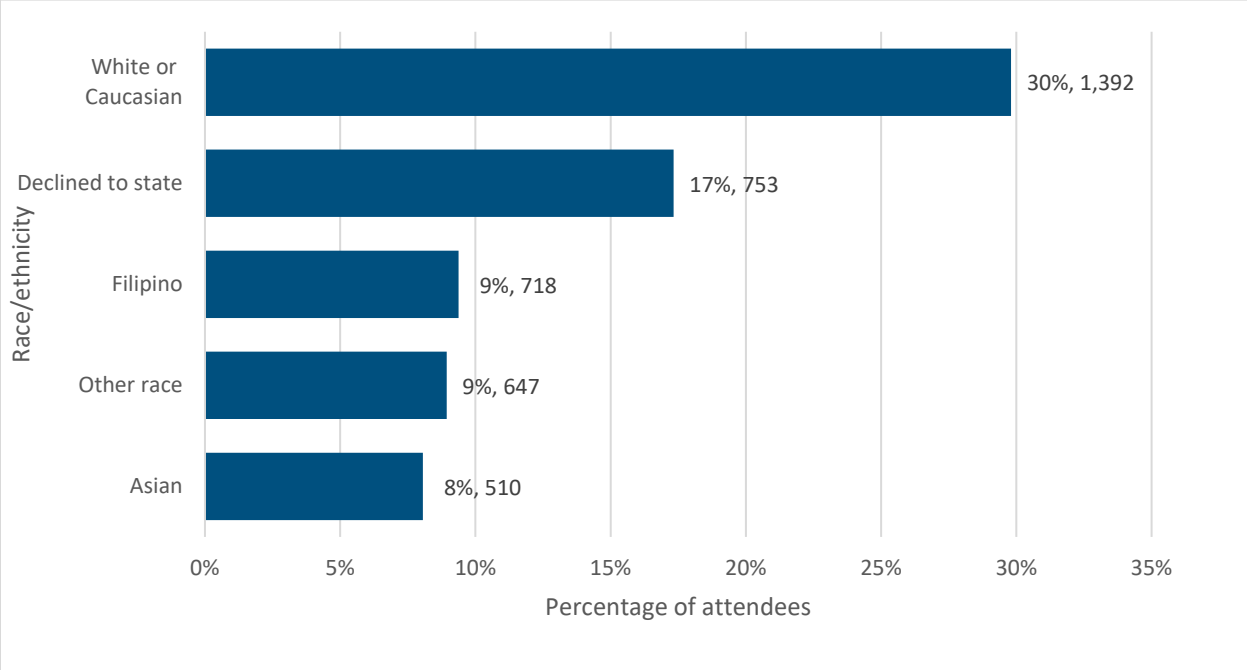
Exhibit 8. Gender of Outreach Attendees Served By NCOC, FY 2021–2022



Note. Percentages may not sum to 100% because of rounding. The total count for gender may exceed the total number of attendees because some providers may have reported individuals in two or more gender groups, leading to extra counts in some cases. The denominator for gender percentage is the sum of all gender data reported.

Race and ethnicity: In FY 2021–2022, the three largest racial/ethnic groups represented by all NCOC attendees were White (30%), Filipino (9%), and Asian (8%). Nine percent of the attendees were Other race and ethnicity, and 17% declined to state their race. See **Exhibit 9** for the number and percentage of attendees representing each reported racial/ethnic group.

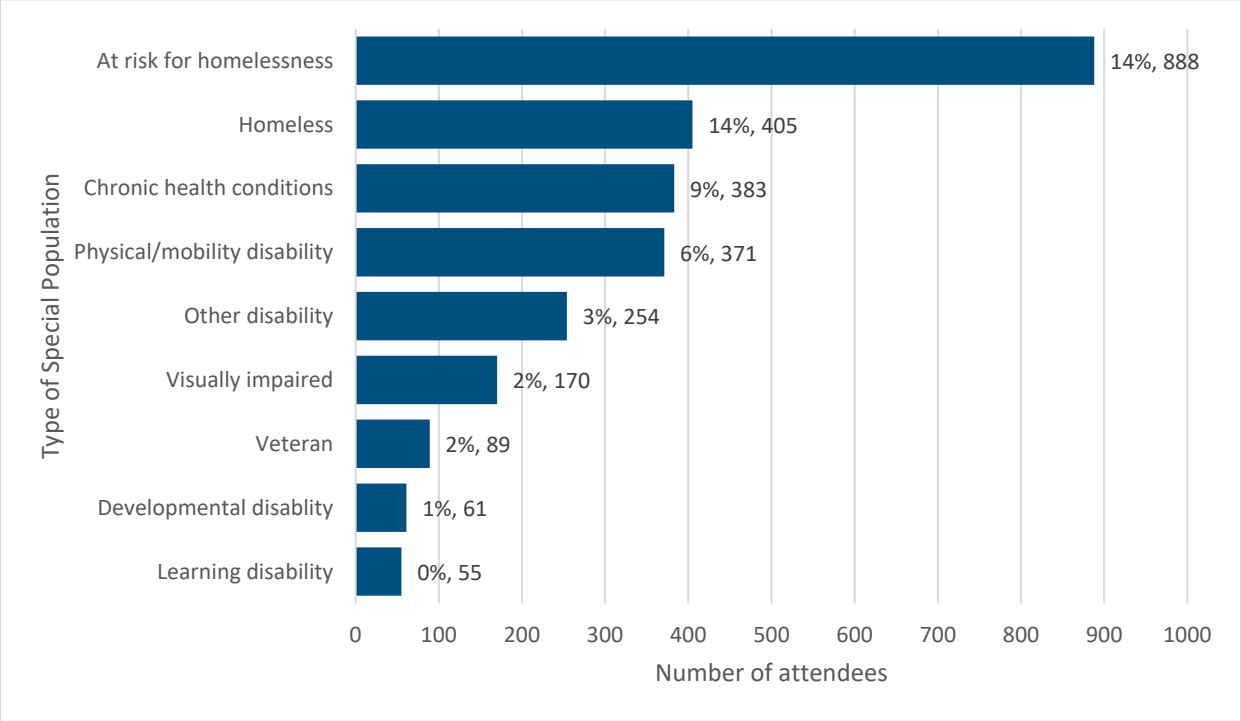
Exhibit 9. Race and Ethnicity of Outreach Attendees Served By NCOC, FY 2021–2022



Note. The denominator for race/ethnicity percentage is the sum of all race/ethnicity data reported. The total count for race/ethnicity may exceed the total number of attendees because some providers may have reported individuals in two or more racial/ethnic groups, leading to extra counts in some cases. The denominator for race/ethnicity percentage is the sum of all race/ethnicity data reported.

Special populations: Of the attendees indicating they were part of special populations, 33% were at risk for homelessness, 15% were homeless, 14% had chronic health conditions, 14% had a physical/mobility disability, 9% had other disabilities, 6% were visually impaired, 3% were veterans, 2% percent had a developmental disability, and 2% had a learning disability. Refer to **Exhibit 10** for the number and percentage of attendees representing each special population in FY 2021–2022.

Exhibit 10. Special Populations Served By NCOC, FY 2021–2022



Note. Attendees could be included in more than one special population. Percentages may not sum to 100% because of rounding. The denominator for special population group is the sum of all special population data reported.

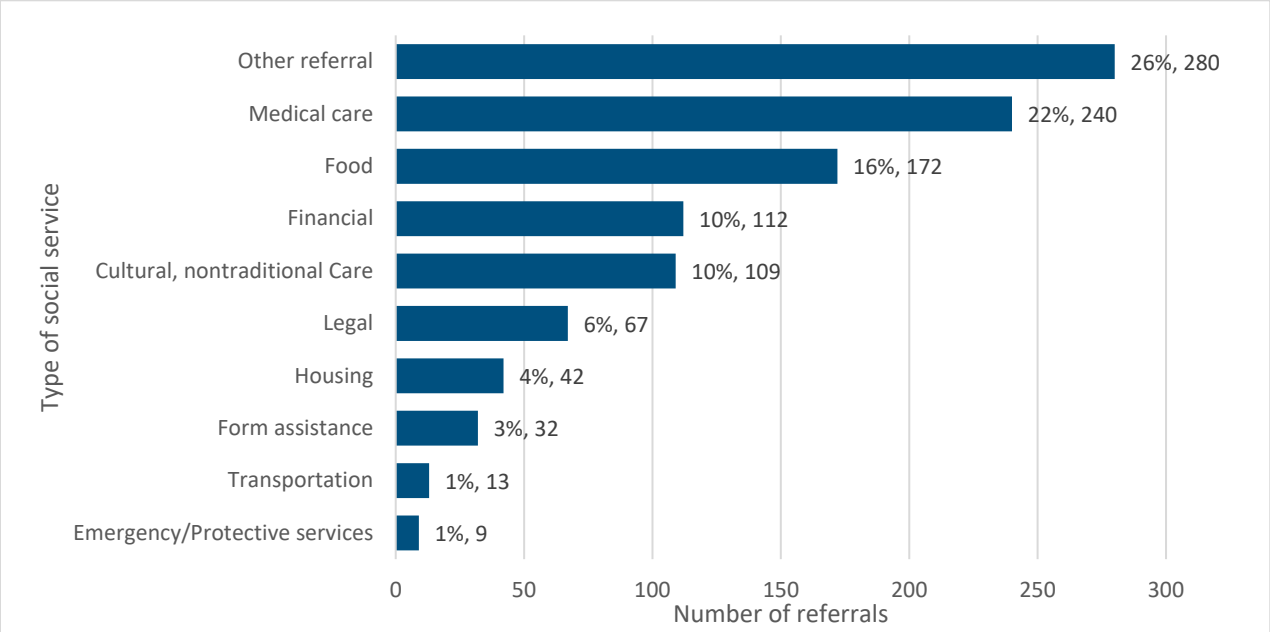
Additional Outreach Characteristics (Individual Outreach Events Only)

Previous contact: One in every three individual outreach events (33%) were conducted with attendees who had attended an outreach event previously.

Mental health/substance use referrals: NCOC individual outreach events resulted in mental health referrals (21%) and substance use referrals (4%) in FY 2021–2022.

Referrals to social services: Providers made 1,081 referrals for 443 NCOC individual outreach attendees. The top four types of referrals made for attendees were "other" category (26%), medical care (22%), food (10%), and financial services (10%). Participants also obtained referrals for cultural, nontraditional care as well as legal assistance and housing assistance. About 1% were referred to transportation or emergency/protective services. **Exhibit 11** summarizes the number and percentage of attendees receiving a given type of referral in FY 2021–2022.

Exhibit 11. Referrals to Social Services, FY 2021–2022



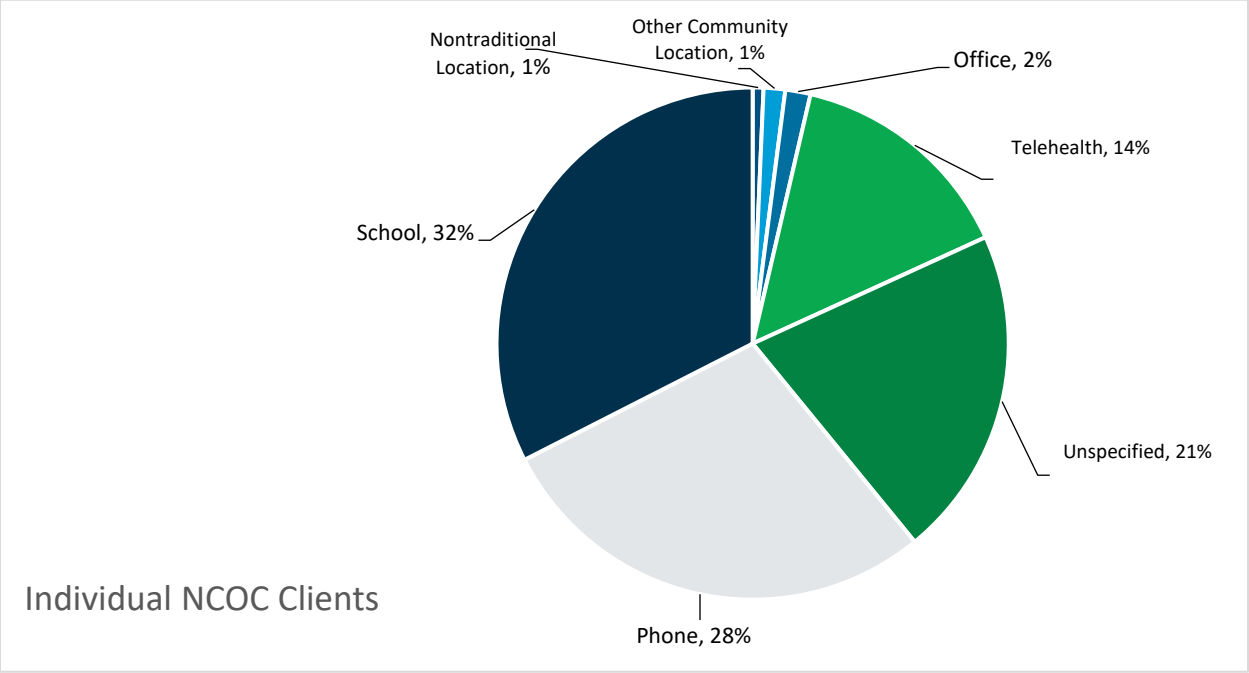
Note. Percentages may not sum to 100% because of rounding. Attendees could choose more than one category. The denominator for referral group is the sum of all referral data reported. Other referrals include services related to COVID-19 testing and vaccinations, the Home Energy Assistance Program (HEAP), and mental health services.

Event Characteristics

Location: Exhibits 12 and 13 present the locations for individual and group outreach events in FY 2021–2022. NCOC individual outreach events occurred primarily at school (32%) or over the phone (8%) in FY 2021–2022. Group outreach events occurred primarily at school (54%), at nontraditional locations (6%), via telehealth (28%), and at other community locations (8%). Other community locations included places such as Boys & Girls Clubs, community centers, the Daly City Youth Health Center, health fairs, fairgrounds, malls, and public parks. The "other

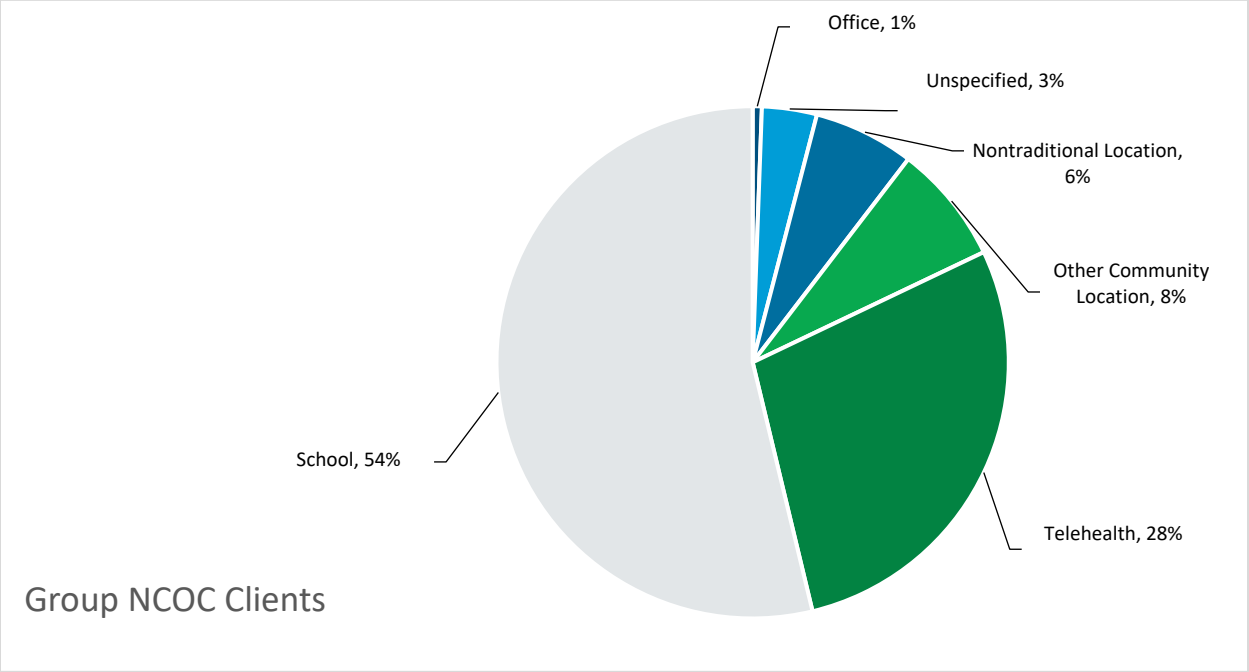
locations" category includes all the locations that were reported that make up less than 10% of the total locations reported.

Exhibit 12. Locations of NCOC Individual Outreach Events, FY 2021–2022



Note. Percentages may not sum to 100% because of rounding.

Exhibit 13. Locations of NCOC Group Outreach Events, FY 2021–2022



Note. Percentages may not sum to 100% because of rounding. Attendees could choose more than one category. The denominator for location percentage is the sum of all location data reported.

Length of contact: For FY 2021–2022, the individual outreach events ranged from 5 to 148 minutes and lasted 35 minutes on average. The average length of NCOC group outreach events ranged from 5 to 371 minutes and lasted 75 minutes on average.

Language used: NCOC individual outreach events were conducted in English (99.5%) and Spanish (0.5%) in FY 2021–2022. NCOC group outreach events were conducted in English (95%) and Spanish (5%) in FY 2021–2022.

Preferred language: Exhibits 14 and 15 present breakdowns of the preferred languages at individual and group outreach events in FY 2021–2022. NCOC individual outreach attendees preferred English (91%), other languages (9%), Tongan (2%), Samoan (2%), Spanish (2%), Cantonese (1%), and Tagalog (1%). NCOC group outreach attendees preferred English (86%), other languages (14%), and Spanish (6%).

Exhibit 14. Preferred Languages of NCOC Individual Outreach Attendees, FY 2021–2022

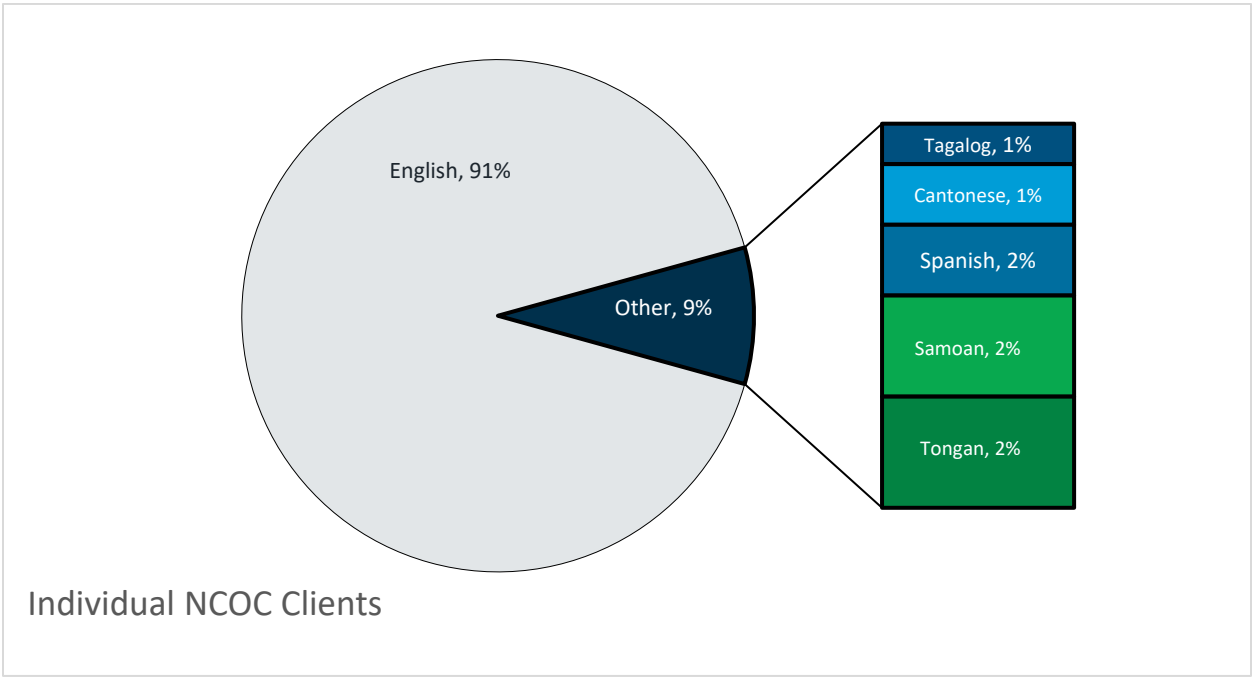
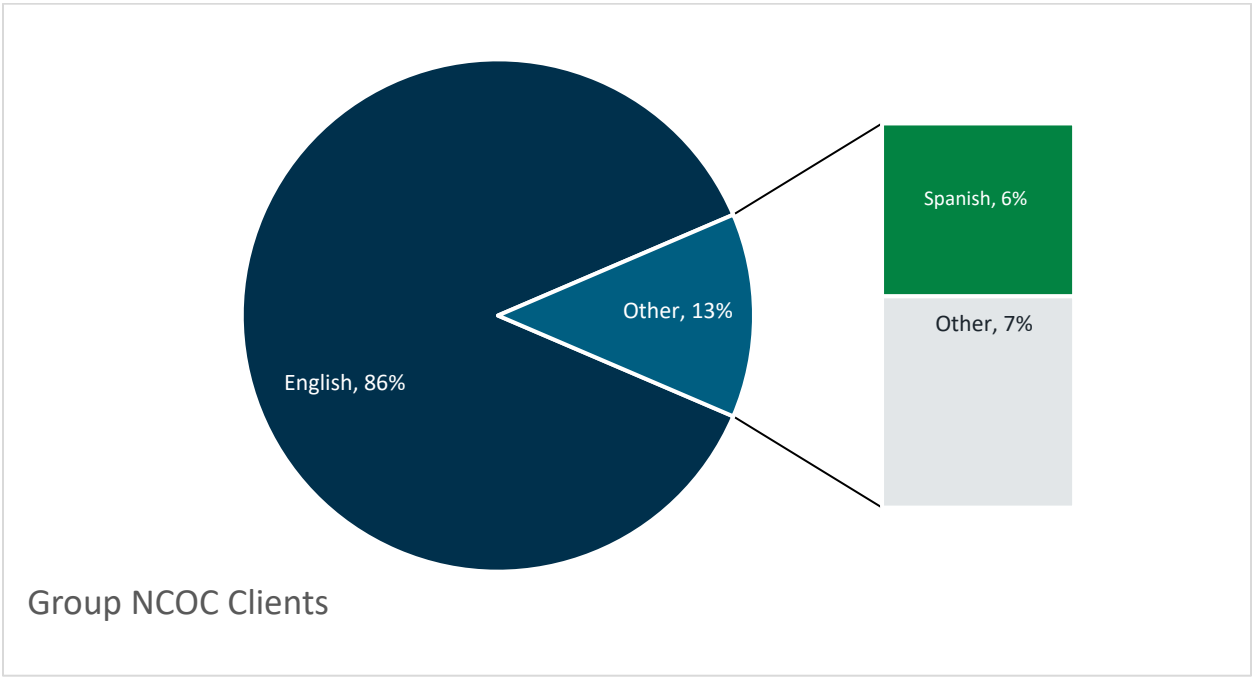


Exhibit 15. Preferred Languages of NCOC Group Outreach Attendees, FY 2021–2022



Note. Percentages may not sum to 100% because of rounding. The denominator for preferred language percentage is the sum of all preferred language data reported.

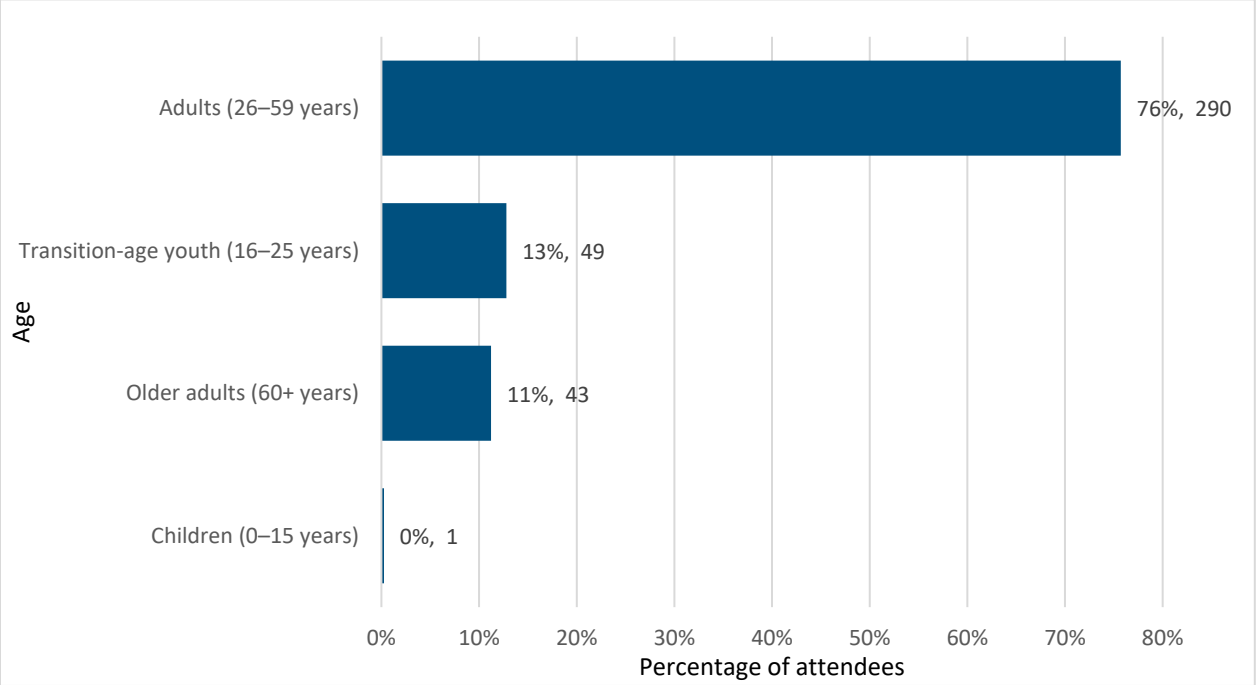
EPAPMHO

This section provides details about 384 attendees at EPAPMHO group and individual outreach events across three provider organizations in FY 2021–2022.

Demographics

Age: Of the EPAPMHO FY 2020–2021 individual and group outreach attendees, 76% were adults (26–59 years of age), 13% were transition-age youth (16–25 years of age), 11% were older adults (60+ years of age and older), and less than 1% were children (0–15 years of age). See **Exhibit 16** for the number and percentage of outreach attendees representing each reported age group.

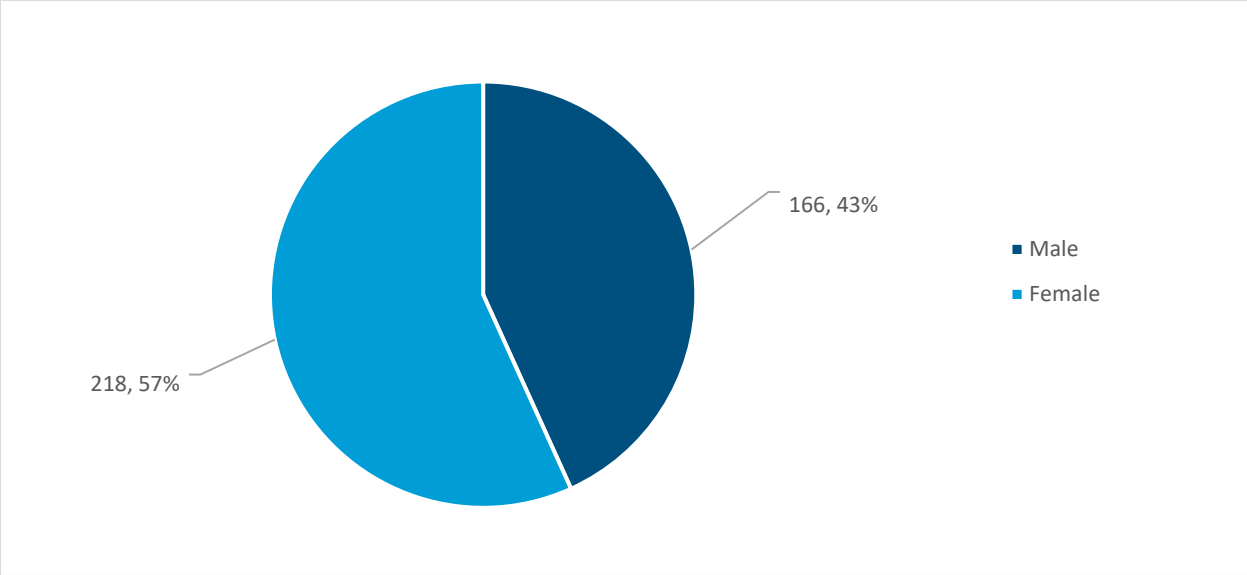
Exhibit 16. Age of Outreach Attendees Served By EPAPMHO, FY 2021–2022



Note. Percentages may not sum to 100% because of rounding. The denominator for age percentage is the sum of all age data reported.

Sex at birth: Attendees across EPAPMHO outreach events indicated their sex at birth as female (57%) or male (43%). See **Exhibit 17** for the number and percentage of outreach attendees reporting sex at birth.

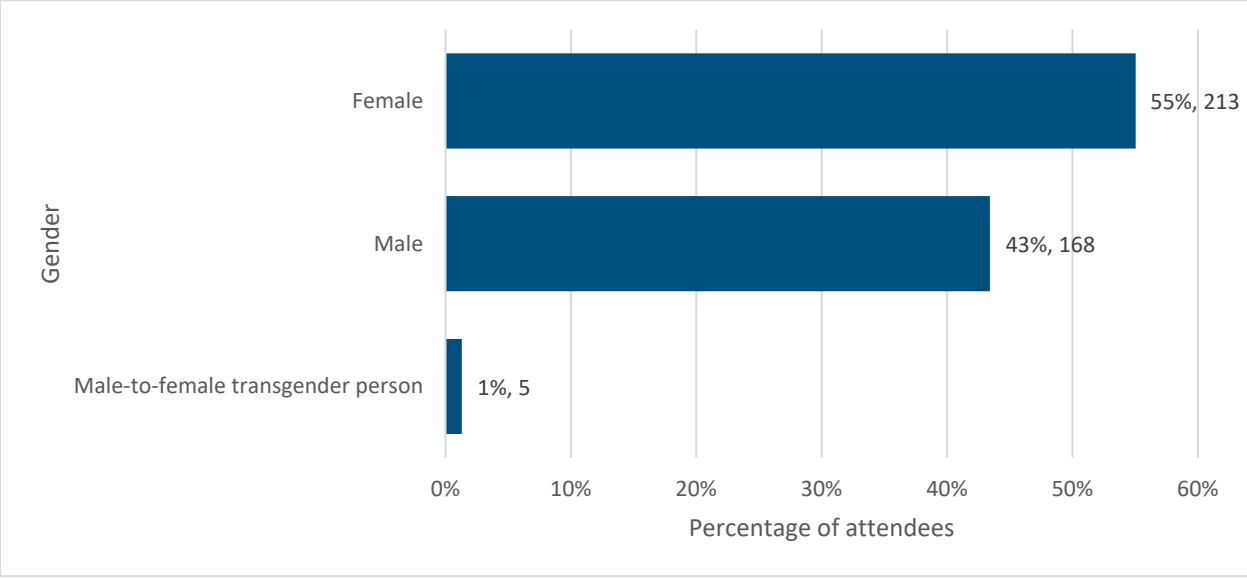
Exhibit 17. Sex at Birth of Outreach Attendees Served By EPAPMHO, FY 2021–2022



Note. Percentages may not sum to 100% percent because of rounding. The denominator for sex percentage is the sum of all sex data reported.

Gender: Attendees across EPAPMHO individual and group outreach events identified themselves primarily as female (55%), male (43%), or male-to-female transgender person (1%). See **Exhibit 18** for the number and percentage of individual and group outreach attendees representing each reported gender.

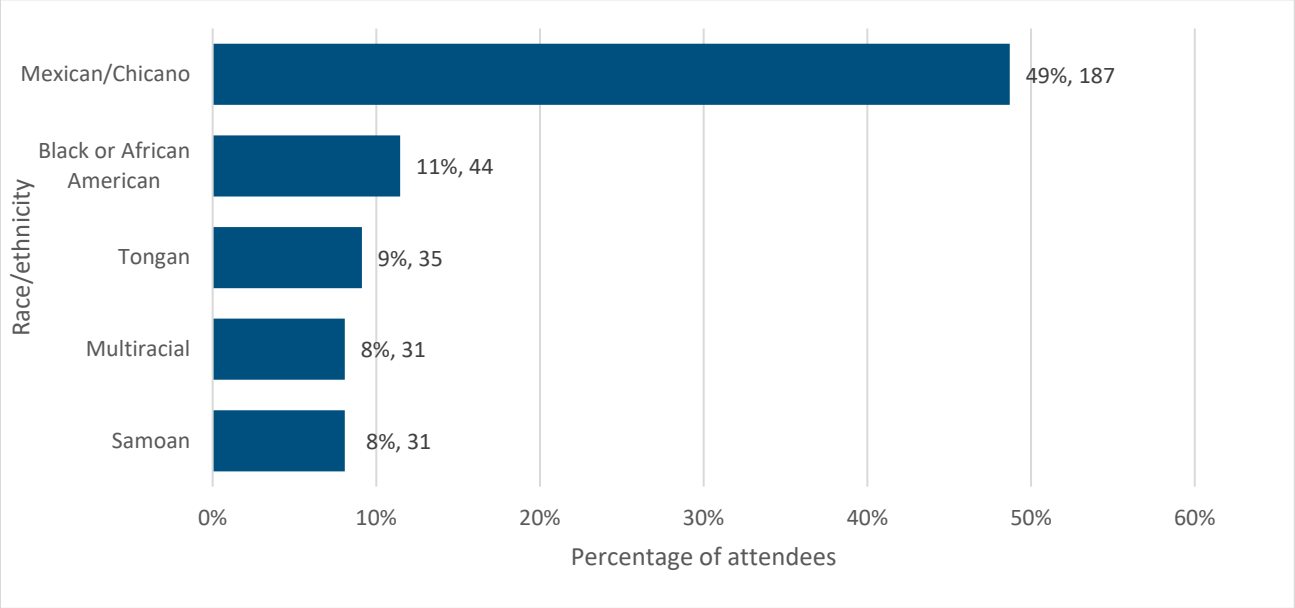
Exhibit 18. Gender of Outreach Attendees Served By EPAPMHO, FY 2021-–2022



Note. Percentages may not sum to 100% because of rounding. The total count for gender may exceed the total number of attendees because some providers may have reported individuals in two or more gender groups, leading to extra counts in some cases. The denominator for gender percentage is the sum of all gender data reported.

Race and ethnicity: In FY 2021–2022, the four largest racial/ethnic groups represented by all EPAPMHO attendees were Mexican (49%), African American (11%), Tongan (9%), and Samoan (8%). Eight percent of the attendees were multiracial. See **Exhibit 19** for the number and percentage of attendees representing each reported racial/ethnic group.

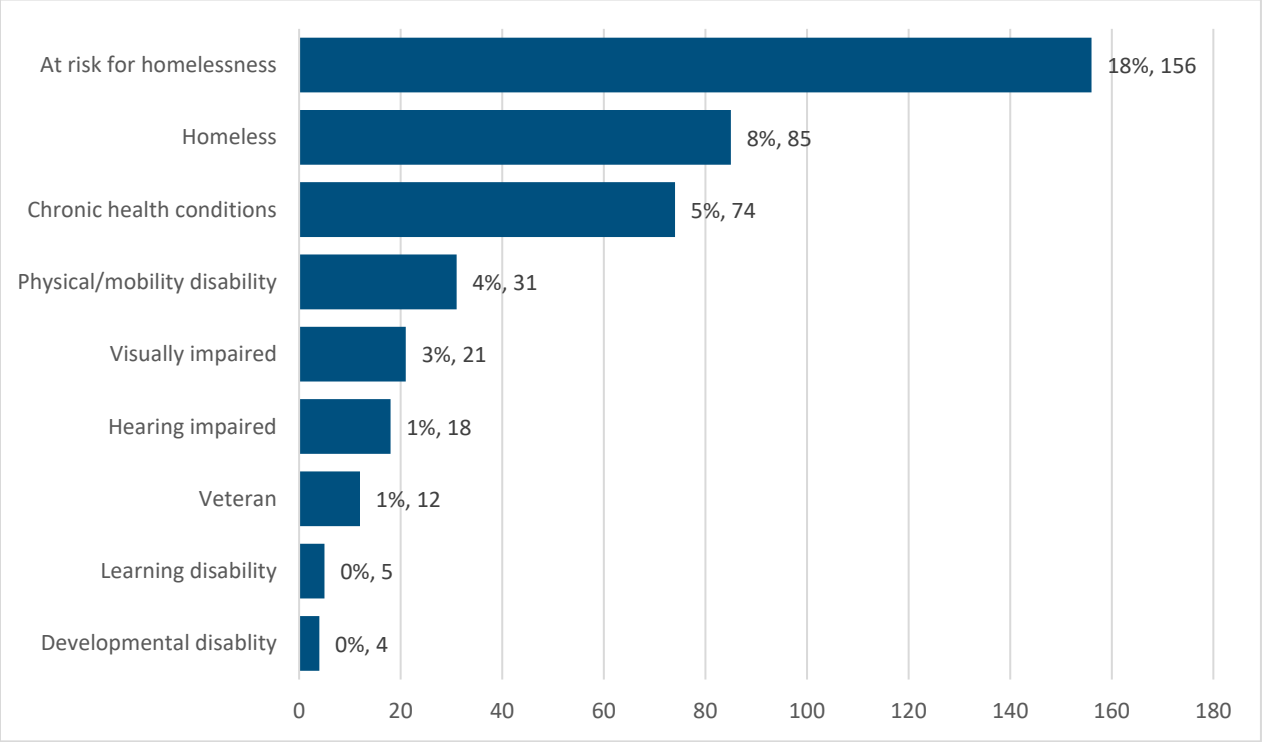
Exhibit 19. Race and Ethnicity of Outreach Attendees Served By EPAPMHO, FY 2021–2022



Note. The total count for race/ethnicity reported may exceed the total number of attendees because some providers may have reported individuals who are multiracial as both multiracial and their respective race/ethnicities, leading to extra counts in some cases. The denominator for race/ethnicity percentage is the sum of all race/ethnicity data reported.

Special populations: Of the special populations, 38% were at risk for homelessness, 21% were homeless, 18% had chronic health conditions, 8% had a physical/mobility disability, 5% were visually impaired, 4% were hearing impaired, 3% were veterans, 1% had a learning disability, and 1% had a developmental disability. Refer to **Exhibit 20** for the number and percentage of attendees representing each special population in FY 2021–2022.

Exhibit 20. Special Populations Served by EPAPMHO, FY 2021–2022



Note. Attendees could be included in more than one special population. The denominator for special population group is the sum of all special population data reported.

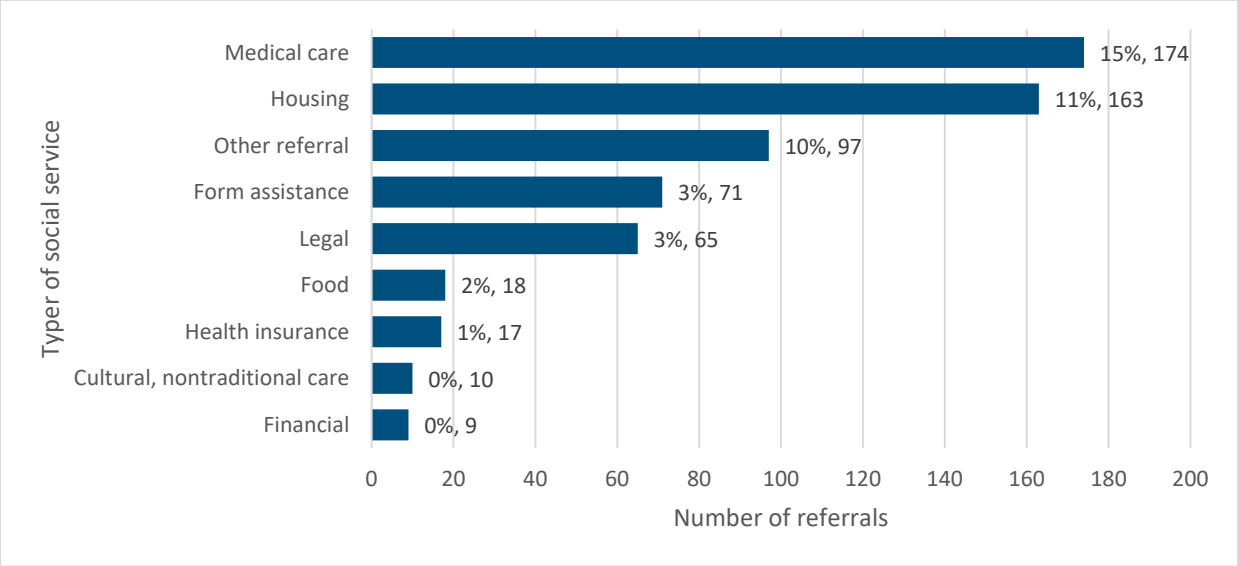
Additional Outreach Characteristics (Individual Outreach Events Only)

Previous contact: Seventeen percent of individual outreach events were conducted with attendees who had a previous outreach contact with EPAPMHO.

Mental health/substance use referrals: EPAPMHO individual outreach events resulted in mental health referrals (26%) and substance use referrals (37%) in FY 2021–2022.

Referrals to social **services:** Providers made 627 referrals to 374 EPAPMHO individual outreach attendees. The top four types of referrals made for attendees were for medical care (15%), housing (11%), other referrals (10%), and form assistance (3%). **Exhibit 21** summarizes the number and percentage of attendees receiving a given type of referral.

Exhibit 21. Referrals to Social Services, FY 2021–2022

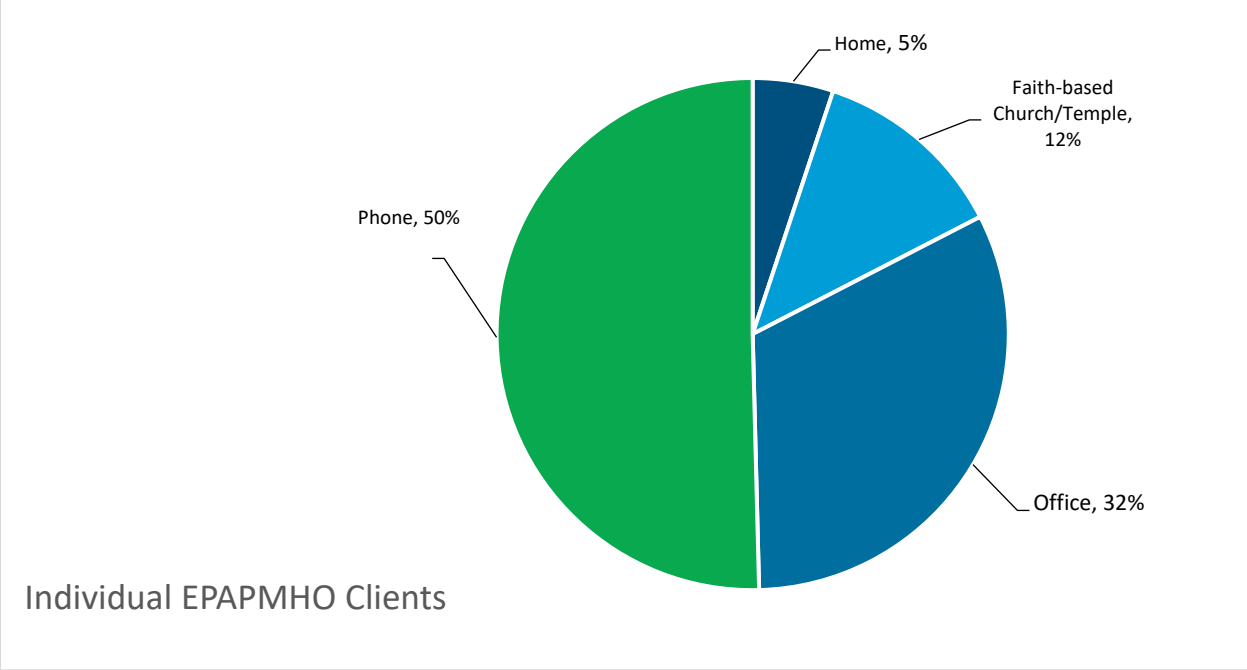


Note. Percentages may not sum to 100% because of rounding. Attendees could choose more than one category. The denominator for referral group is the sum of all referral data reported.

Event Characteristics

Location: EPAPMHO individual outreach events occurred over the phone (50%), in offices (32%), at faith-based churches/temples (12%), or at home (5%). **Exhibit 22** presents individual outreach event locations. The only EPAPMHO group outreach event occurred in an office.

Exhibit 22. Location of EPAPMHO Individual Outreach Events, FY 2021–2022



Length of contact: In FY 2021–2022, the individual outreach events lasted from 10 to 30 minutes and averaged 16 minutes. The only group outreach events lasted 30 minutes.

Language used: EPAPMHO individual outreach events were conducted in Spanish (59%), English (27%), Tongan (7%), and Samoan (6%). The single group outreach event was conducted in Tongan.

Preferred language: EPAPMHO individual outreach attendees preferred Spanish (60%), English (26%), other languages (14%), Tongan (7%), and Samoan (6%). Attendees at the EPAPMHO group outreach events preferred Tongan (50%) and Samoan (50%). **Exhibits 23 and 24** present breakdowns of preferred languages at individual and group outreach events in FY 2021–2022.

Exhibit 23. Preferred Languages of EPAPMHO Individual Outreach Attendees, FY 2021–2022

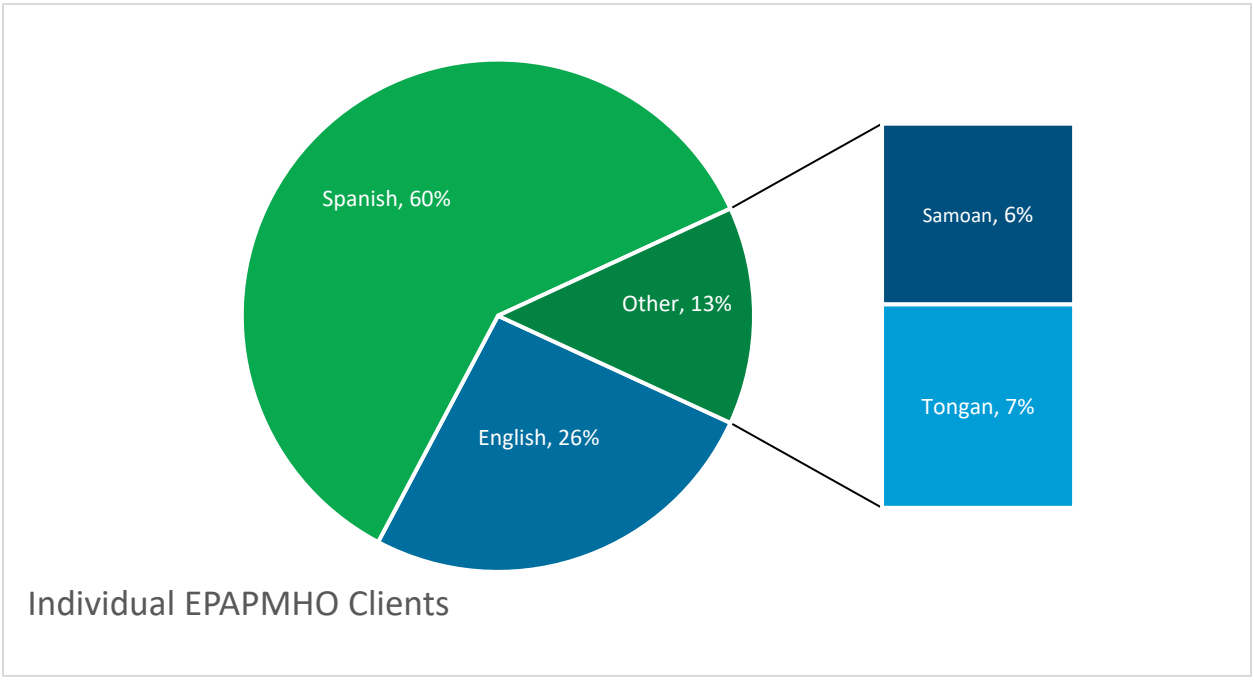
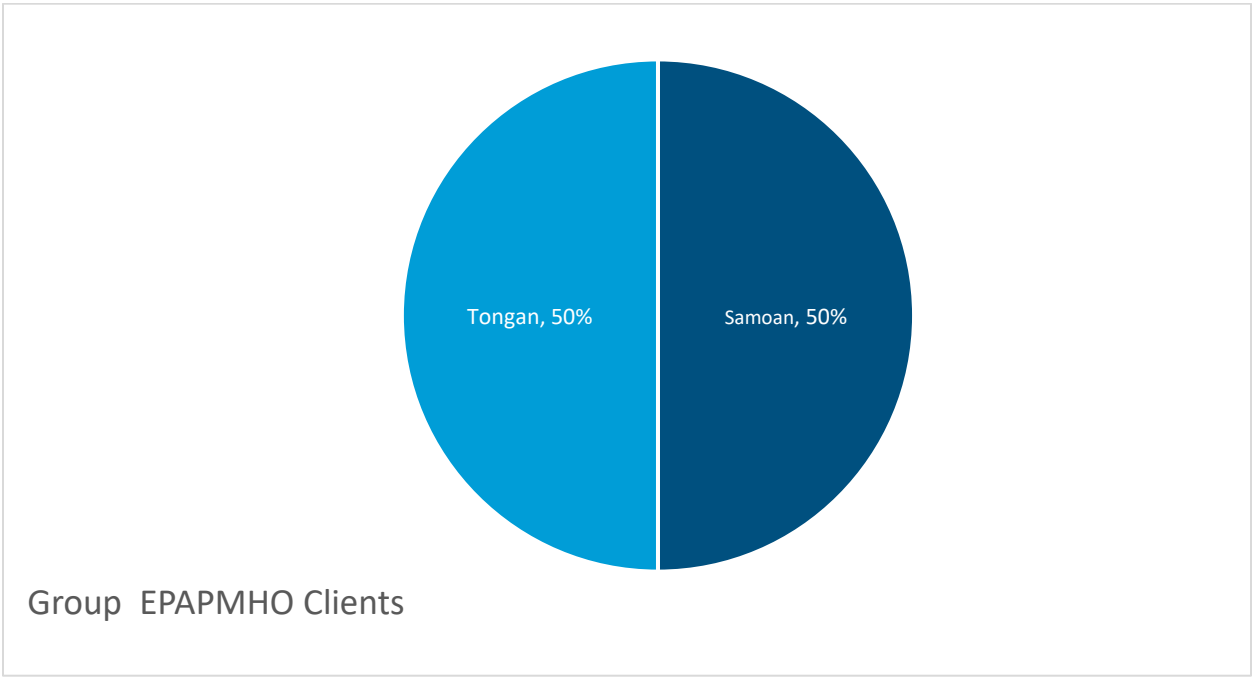


Exhibit 24. Preferred Languages of EPAPMHO Group Outreach Attendees, FY 2021–2022



Appendix A. FY 2021–2022 Outreach, Anamatangi Polynesian Voices

For FY 2021–2022, Anamatangi Polynesian Voices reported 55 outreach events, which included 54 individual events and 1 group event. There were 64 attendees, and all individual and group events lasted 30 minutes.

Outreach events

- Most frequently took place in an office (**47.3%**; *n* = 26). Other locations for events and their respective percentages are shown in **Exhibit A1.**
- Were conducted in Tongan (49.1%; *n* = 27), Samoan (43.6%; *n* = 24), and English (7.3%; *n* = 4).
- Resulted in 52 mental health referrals and 1 substance use referral.
- Resulted in 75 social services referrals. (See Exhibit A2.) An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made primarily to legal (42.7%; *n* = 32); form assistance (16.0%, *n* = 12); cultural, nontraditional care (13.3%, *n* = 10); and food (9.3%; *n* = 7) services.

Exhibit A1. Locations of Anamatangi Polynesian Voices Outreach Events, FY 2021–2022

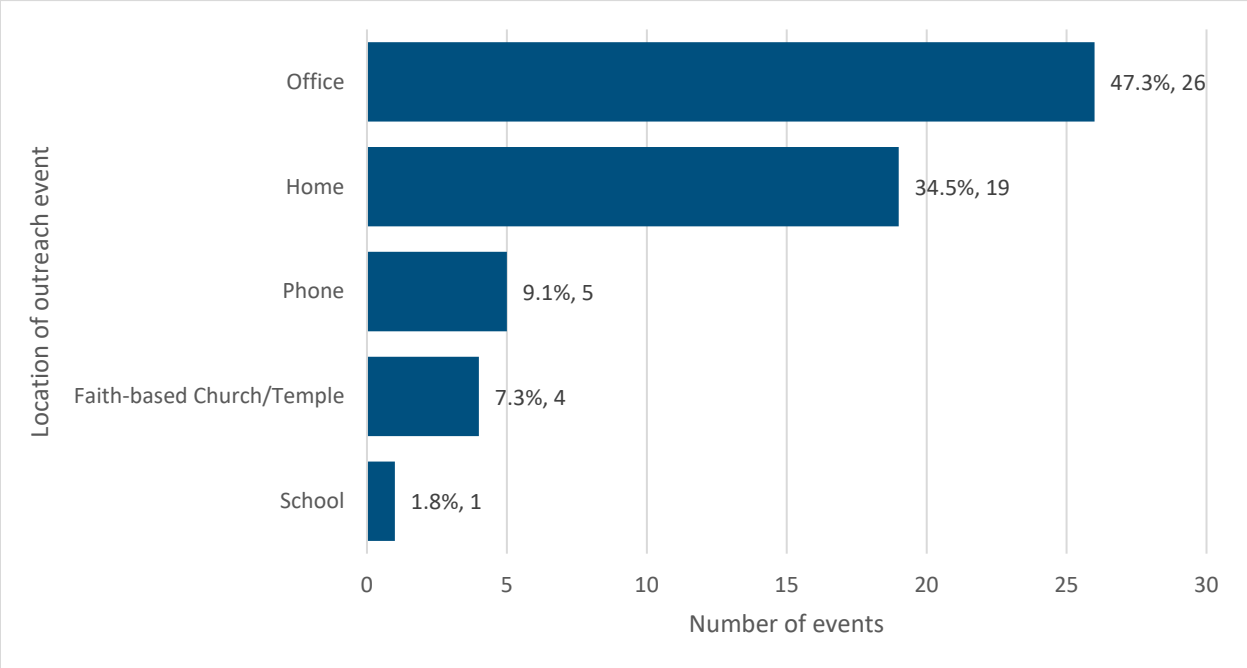
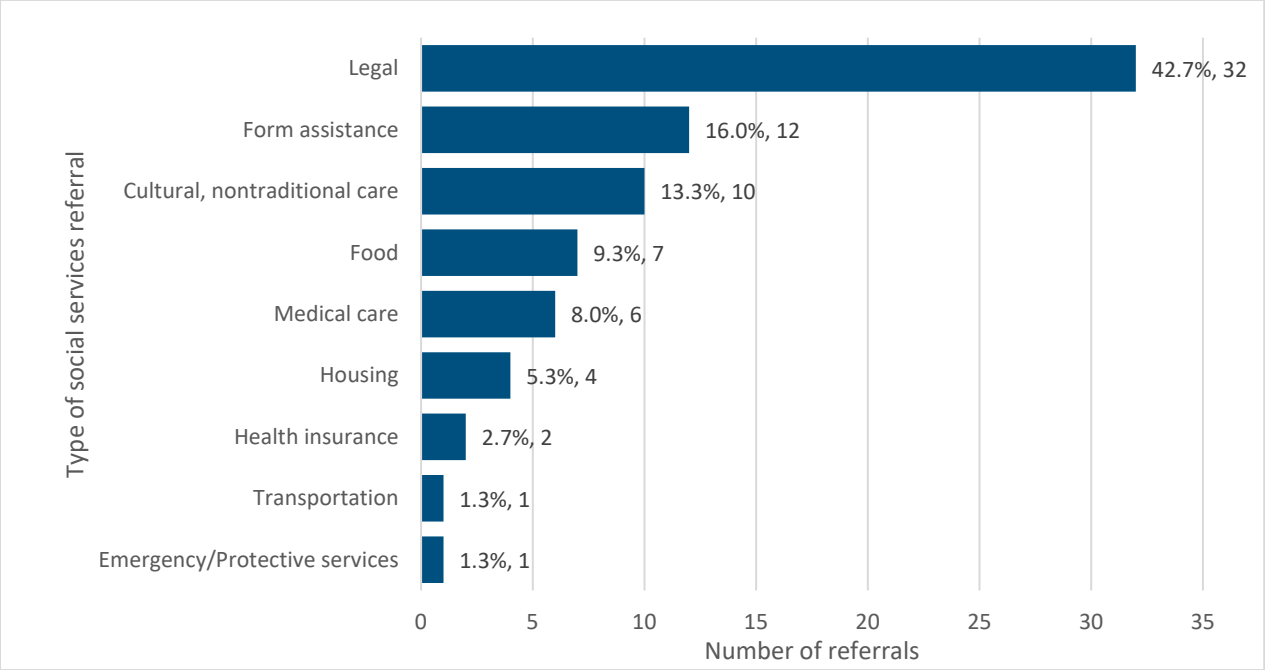


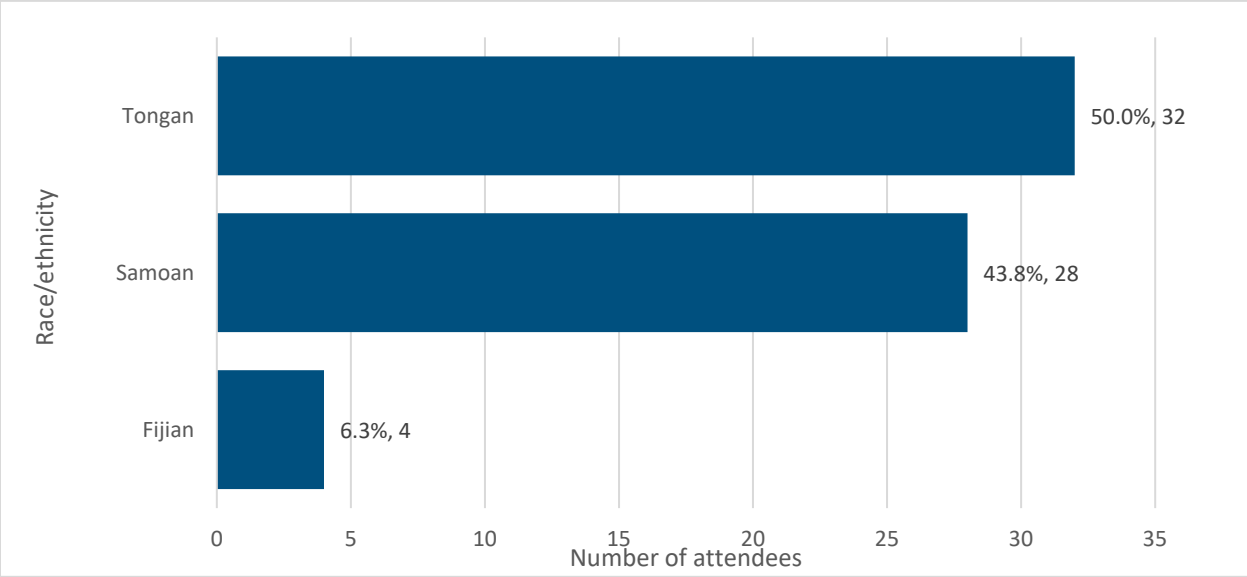
Exhibit A2. Anamatangi Polynesian Voices Social Services Referrals, FY 2021–2022



Outreach event attendees

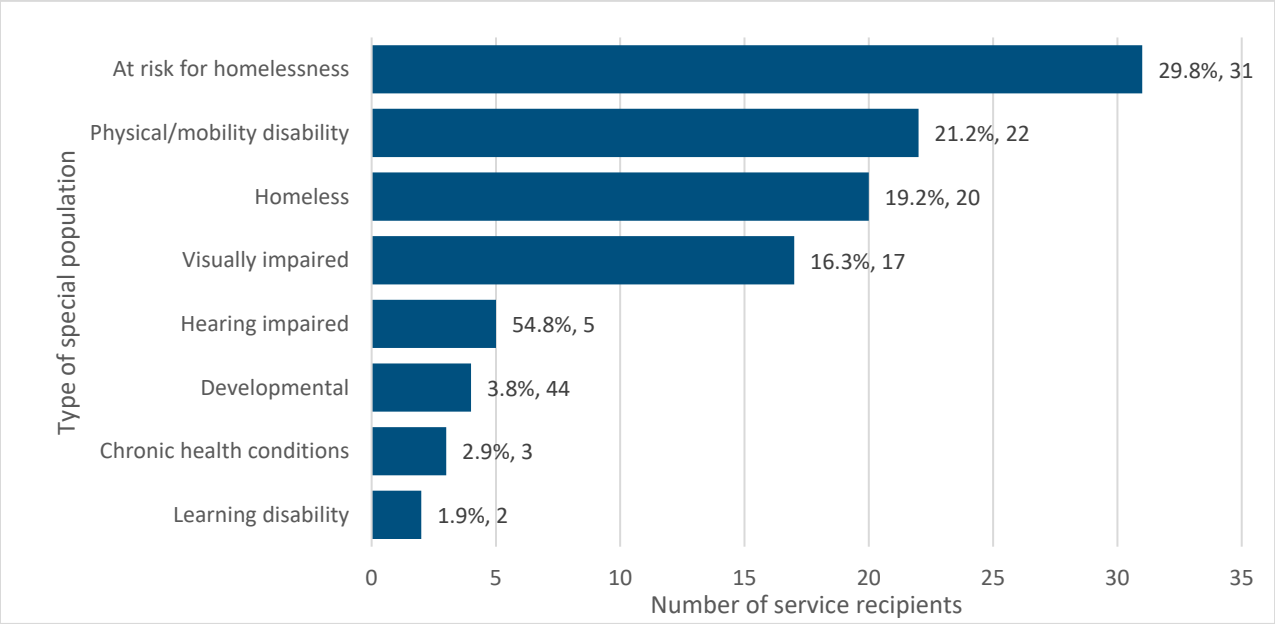
- Were male (60.9%; *n* = 39); 39% were female (39.1%, *n* = 25).
- Identified their gender as male (60.0%; *n* = 39); 39% identified as female (40.0%; *n* = 26).
- Identified as heterosexual (96.9%; *n* = 62), or gay/lesbian (3.1%; *n* = 2).
- Included adults (26–59 years of age; 55.6%; *n* = 35), older adults (60 years of age and older; 27.0%; *n* = 17), and transition-age youth (16–25 years of age; 17.5%; *n* = 11).
- Were primarily Tongan (50.0%, *n* = 32) or Samoan (43.8%; *n* = 28). (See Exhibit A3.)

Exhibit A3. Anamatangi Polynesian Voices Attendees by Top Racial/Ethnic Category, FY 2021–2022



In FY 2021–2022, Anamatangi Polynesian Voices attendees reported being in special populations groups. Out of the service recipients in the special population groups, **29.8%** were at risk for homelessness, **21.2%** had a mobility disability, and **19.2%** were homeless. (See **Exhibit A4**.) They also reported being visually impaired or hearing impaired, having a developmental disability or chronic health conditions, and having a learning disability.

Exhibit A4. Anamatangi Polynesian Voices Service Recipients by Special Population, FY 2021–2022



Appendix B. FY 2021–2022 Outreach, Asian American Recovery Services (AARS)

For FY 2021–2022, Asian American Recovery Services (AARS) reported 206 outreach events, which included 191 individual events and 15 group events. There were 547 attendees. Individual outreach events lasted from 5 to 120 minutes and lasted 29 minutes on average. The group outreach events lasted from 30 to 120 minutes and lasted on average 76 minutes.

Outreach events

- Were most often held over the phone (**42.7%**, *n* = 88). Other locations of events and their respective percentages are shown in **Exhibit B1**.
- Were conducted in English (100%; *n* = 206).
- Resulted in 66 mental health referrals and 19 substance use referrals at the individual outreach events.
- Resulted in 795 social services referrals (**Exhibit B2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made to other services primarily including COVID-19 testing (23.3%; *n* = 185); food (18.1%; *n* = 144); medical care (17.5%; *n* = 139); cultural, nontraditional care (13.7%; *n* = 109); and financial (12.7%; *n* = 101) services.

Exhibit B1. Locations of AARS Outreach Events, Fiscal Year 2021–2022

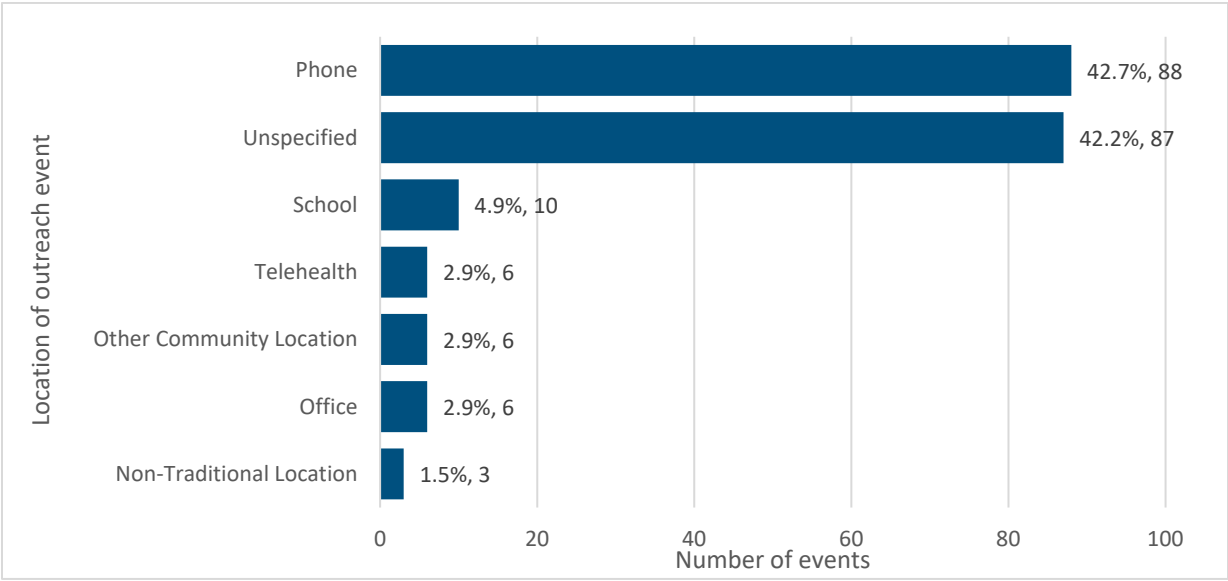
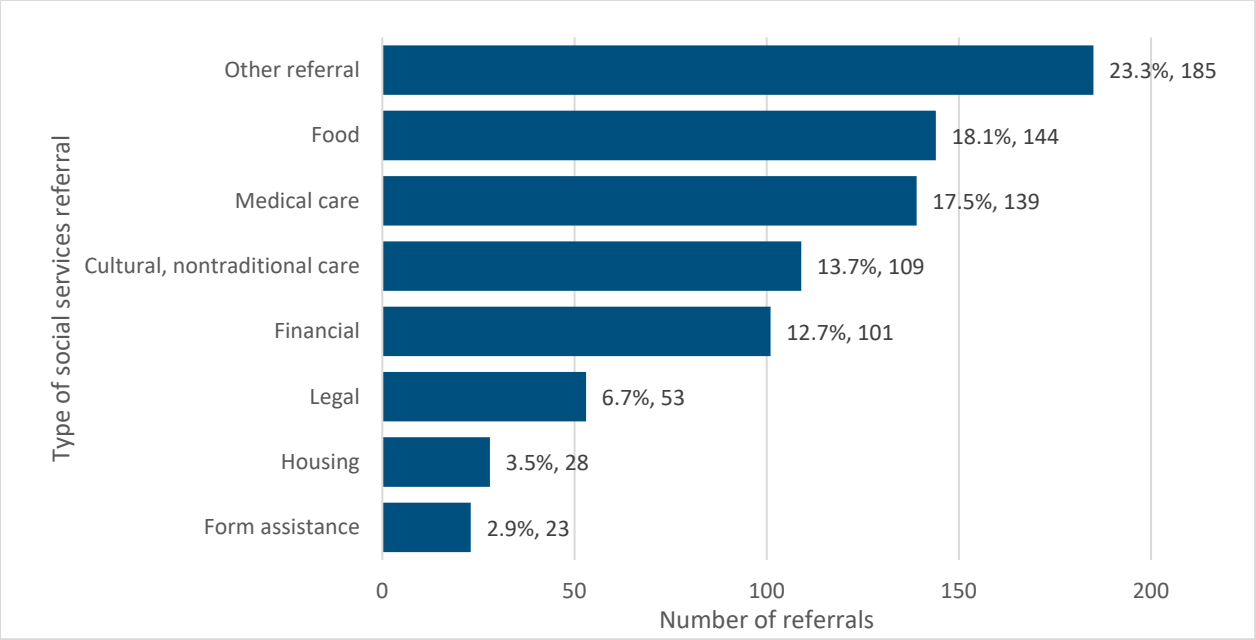


Exhibit B2. AARS Social Services Referrals, FY 2021–2022

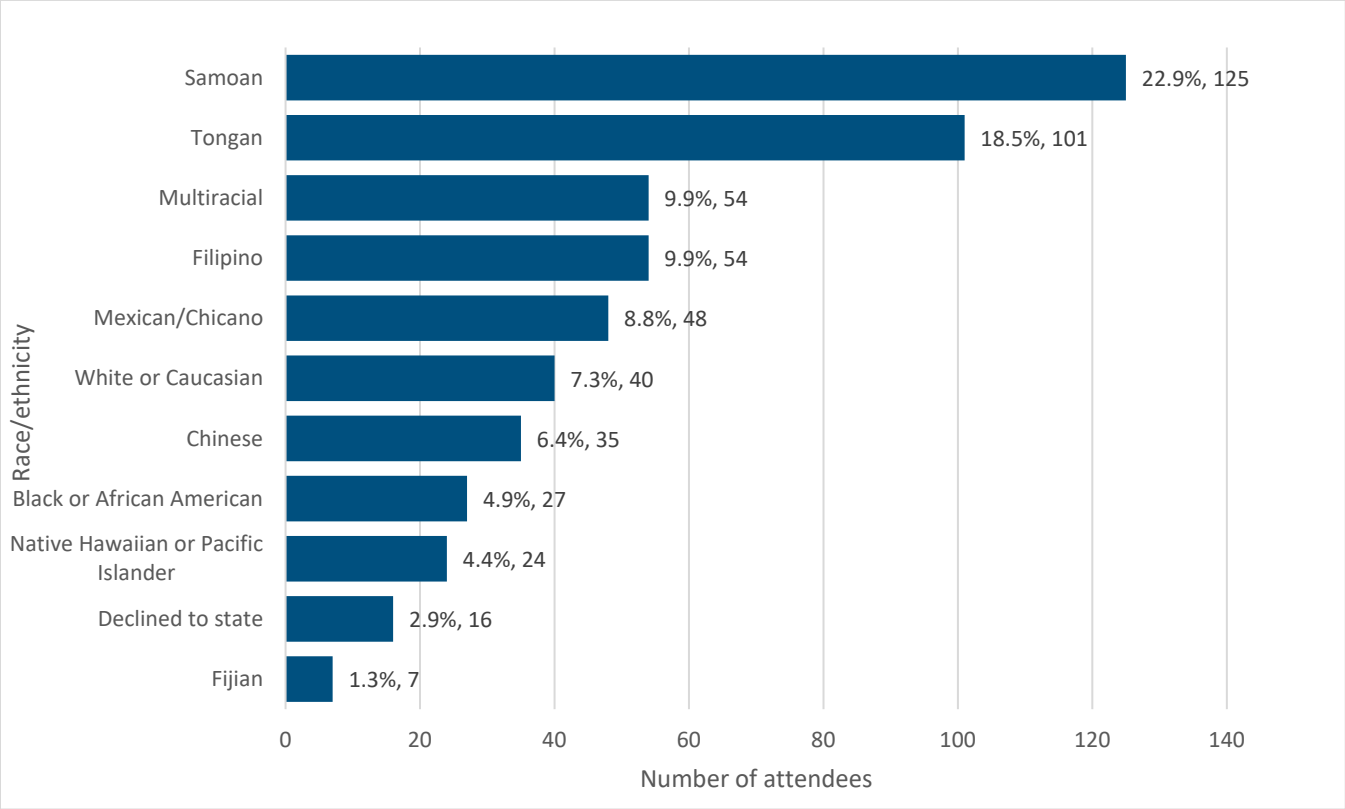


Note. Other referrals include services related to COVID-19 testing and vaccinations, the Home Energy Assistance Program (HEAP), and mental health services.

Outreach event attendees

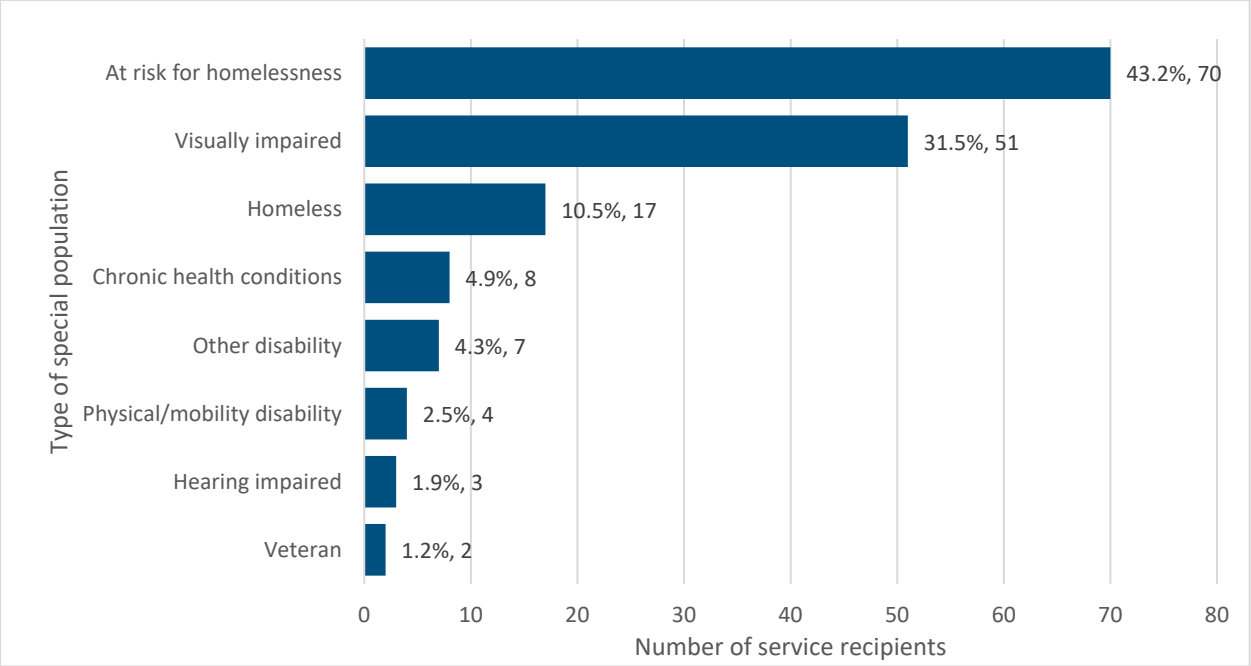
- Were female (**66.9%;** *n* = 366). Thirty percent were male (**30.2%;** *n* = 165). Close to 3% declined to report their sex at birth (2.7%; *n* = 15).
- Identified their gender as female (**64.1%;** *n* = 350), male (**27.8%;** *n* = 152); female-to-male transgender (**0.2%;** *n* = 1); and male-to-female transgender (**0.2%;** *n* = 1). Forty-two attendees declined to state their gender (7.7%).
- Identified as heterosexual (**66.9%;** *n* = 366), bisexual (**3.7%;** *n* = 20), gay/lesbian (**2.0%;** *n* = 11), queer (**1.8%;** *n* = 10), questioning orientation (**0.7%;** *n* = 4); or pansexual (**0.2%;** *n* = 1). The remaining attendees declined to state their sexual orientation (**24.7%;** *n* = 135).
- Included adults (26–59 years of age; **48.3%**; *n* = 263), children (15 years of age and younger; **22.8%**; *n* = 124), transition-age youth (16–25 years of age; **21.7%;** *n* = 118), older adults (60 years of age and older; **2.8%;** *n* = 15), and unknown age (**4.6%;** *n* = 25).
- Were primarily Samoan (**22.9%;** *n* = 125), Tongan (**18.5**%; *n* = 101), and more than one race (**9.9%;** *n* = 54). (See **Exhibit B3**.)

Exhibit B3. AARS Attendees by Top Racial/Ethnic Category, FY 2021–2022



In FY 2021–2022, AARS attendees reported being in special populations groups. Out of the recipients in the special population groups, **43.2%** were at risk for homelessness, **31.5%** were visually impaired, and **10.5%** were homeless (See **Exhibit B4**.) They also reported having other chronic health conditions, other disabilities, or a physical/mobility disability; being hearing impaired; or being a veteran.

Exhibit B4. AARS Service Recipients by Special Population, FY 2021–2022



Appendix C. FY 2021–2022 Outreach, Daly City Peninsula Partnership Collaborative

For FY 2021–2022, Daly City Peninsula Partnership Collaborative reported 143 outreach events, including 110 individual events and 33 group events. There were 858 attendees at these vents. Individual outreach events lasted 45 minutes on average. The group outreach events lasted from 30 to 270 minutes and lasted 85 minutes on average.

Outreach events

- Took place via telehealth most often (**62.2%;** *n* = 89). Other locations of events and their respective percentages are shown in **Exhibit C1.**
- Were conducted in English (**100%;** *n* = 143).
- Resulted in nine mental health referrals and no substance use referrals at the individual outreach events.
- Resulted in 241 social services referrals (**Exhibit C2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were primarily made to medical care (**41.1%;** *n* = 99), other referrals (**37.3%;** *n* = 90), food (**6.2%;** *n* = 15), and legal services (**5.8%;** *n* = 14).

Exhibit C1. Locations of Daly City Peninsula Partnership Collaborative Outreach Events, FY 2021–2022

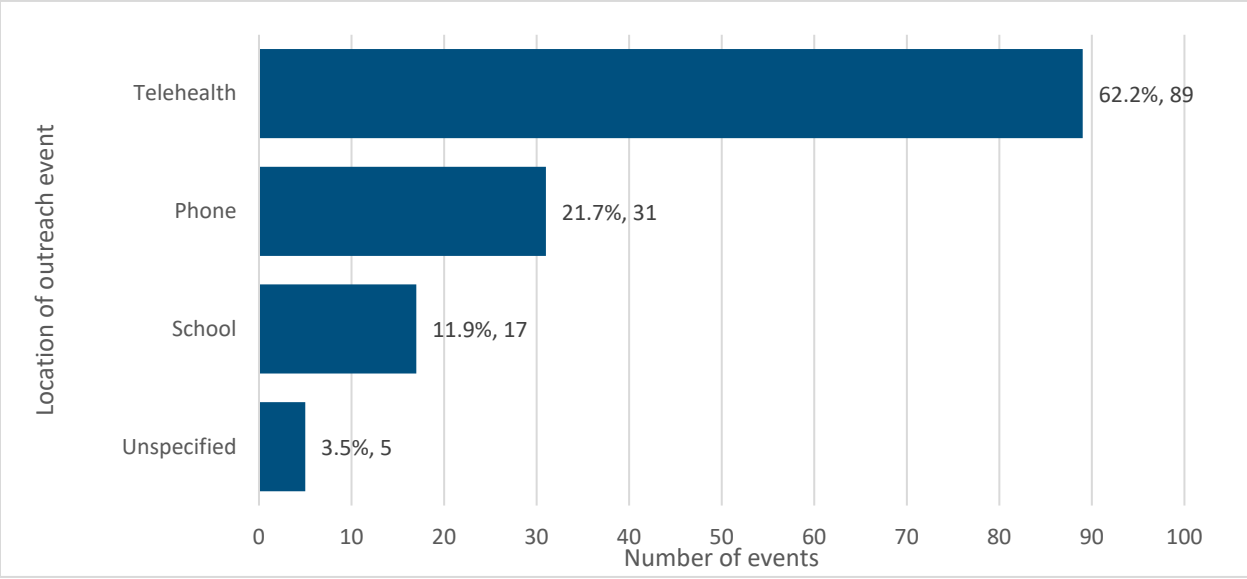
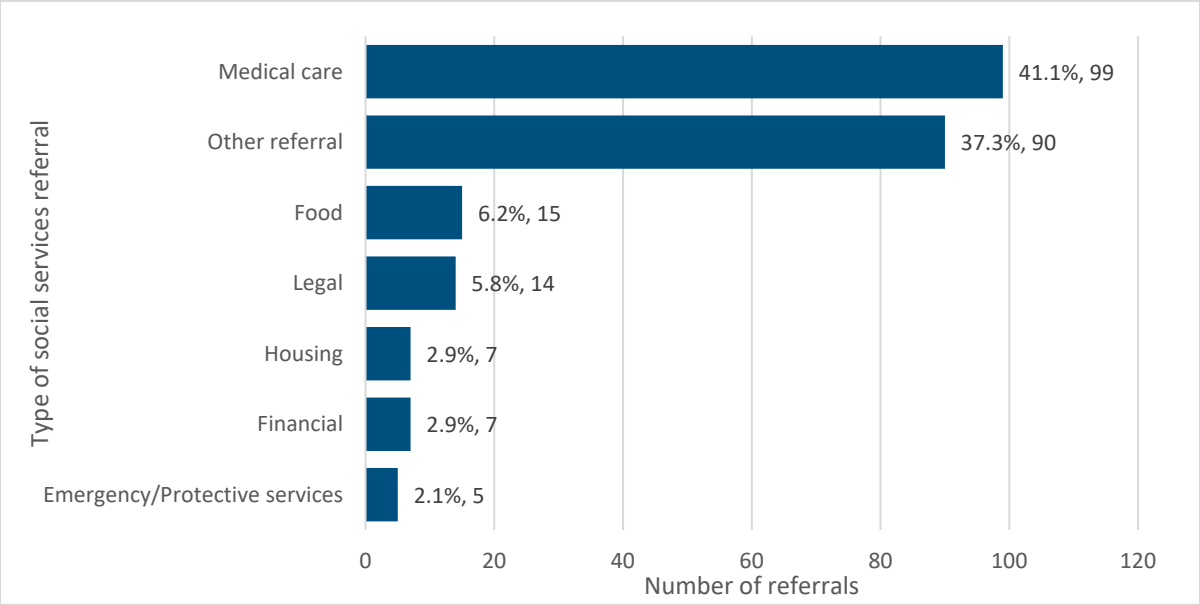


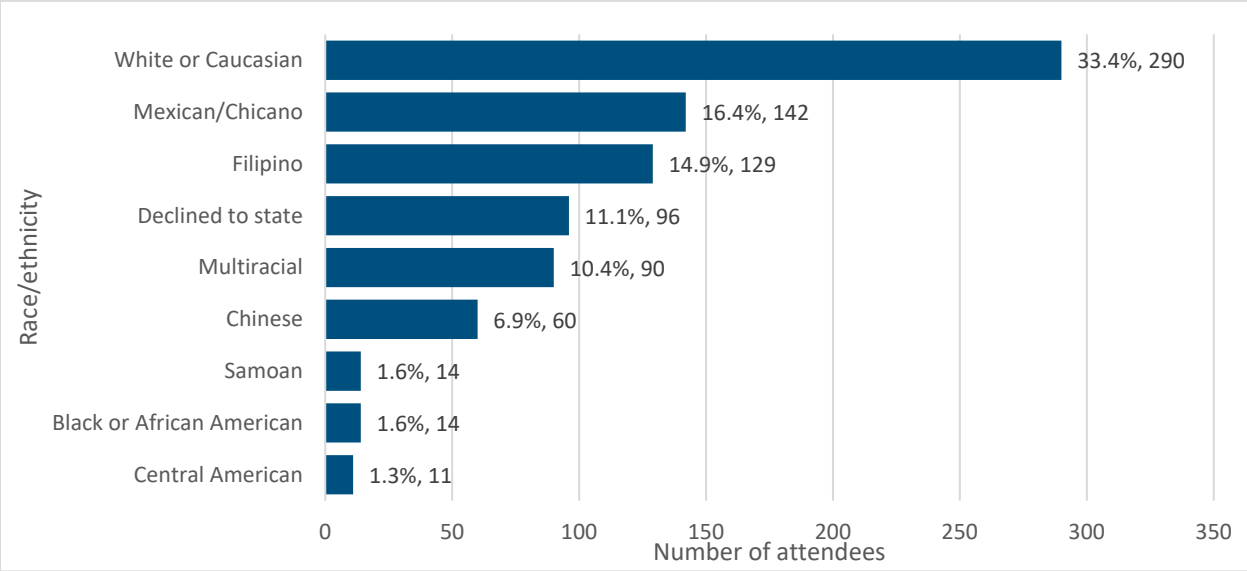
Exhibit C2. Daly City Peninsula Partnership Collaborative Social Services Referrals, FY 2021–2022



Outreach event attendees

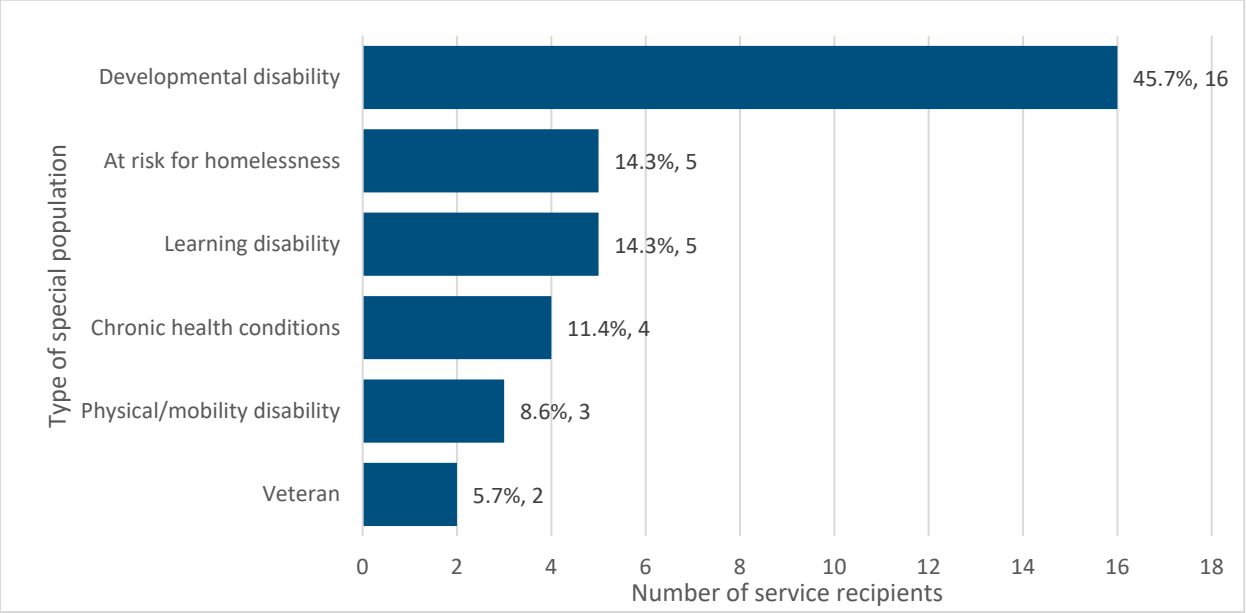
- Were female most often (**53.3%;** *n* = 458). Twenty-two percent identified as male (**22.2%;** *n* = 191). Almost one in four attendees (24.4%; *n* = 210) declined to state their sex at birth.
- Identified their gender as female (**54.3%;** *n* = 470), male (**19.8%**; *n* = 171), and queer (4.6%; *n* = 40). More than one in five attendees (21.3%; *n* = 184) declined to state their gender.
- Identified as heterosexual (**40.4%;** *n* = 347), bisexual (7.5%; *n* = 64); gay/lesbian (**7.3%;** *n* = 63), queer (0.6%; *n* = 5), or questioning (**0.5%;** *n* = 4). Forty-four percent of attendees (**43.7%;** *n* = 375) declined to state their sexual orientation.
- Included adults (26–59 years of age; **25.2%;** *n* = 216), children (15 years of age and younger; **14.5%;** *n* = 124), older adults (60 years of age and older; 5.8%; *n* = 50), and transition-age youth (16–25 years of age; **4.0%;** *n* = 34). More than half of attendees (**50.6%;** *n* = 434) declined to state their age.
- Were White (**33.4%;** *n* = 290), Mexican (**16.4%;** *n* = 142), or Filipino (**14.9%;** *n* = 129) (See **Exhibit C3**.)

Exhibit C3. Daly City Peninsula Partnership Collaborative Attendees by Top Race/Ethnicity Category, FY 2021–2022



In FY 2021–2022, Daly City Peninsula Partnership attendees reported being in special populations groups. Among recipients in the special population groups, **45.7%** had a developmental disability, **14.3%** were at risk for homelessness, and **14.3%** had a learning disability. (See **Exhibit C4.**) They also reported having chronic health conditions, a physical/mobility disability, or being a veteran.

Exhibit C4. Daly City Peninsula Partnership Collaborative Service Recipients by Special Population, FY 2021–2022



Appendix D. FY 2021–2022 Outreach, Daly City Youth Center

For FY 2021–2022, Daly City Youth Center reported 237 outreach events, including 128 individual events and 109 group events. There were 2,925 attendees. Individual outreach events lasted from 5 to 371 minutes and lasted 66 minutes on average. The group outreach events lasted from 8 to 148 minutes and lasted 35 minutes on average.

Outreach events

- Took place at schools most of the time (**85.7%**, *n* = 203). Other locations for events and their respective percentages are shown in **Exhibit D1.**
- Were conducted in English (**95.4%**, *n* = 226) and Spanish (**4.6%,** *n* = 11).
- Resulted in 40 mental health referrals and no substance use referrals at the individual outreach events.
- Resulted in 12 social services referrals (**Exhibit D2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were primarily made to other referrals (**41.7%;** *n* = 5), food (**25%;** *n* = 3), and medical care (**16.7%;** *n* = 2) services.

Exhibit D1. Daly City Youth Center Locations of Outreach Events, FY 2021–2022

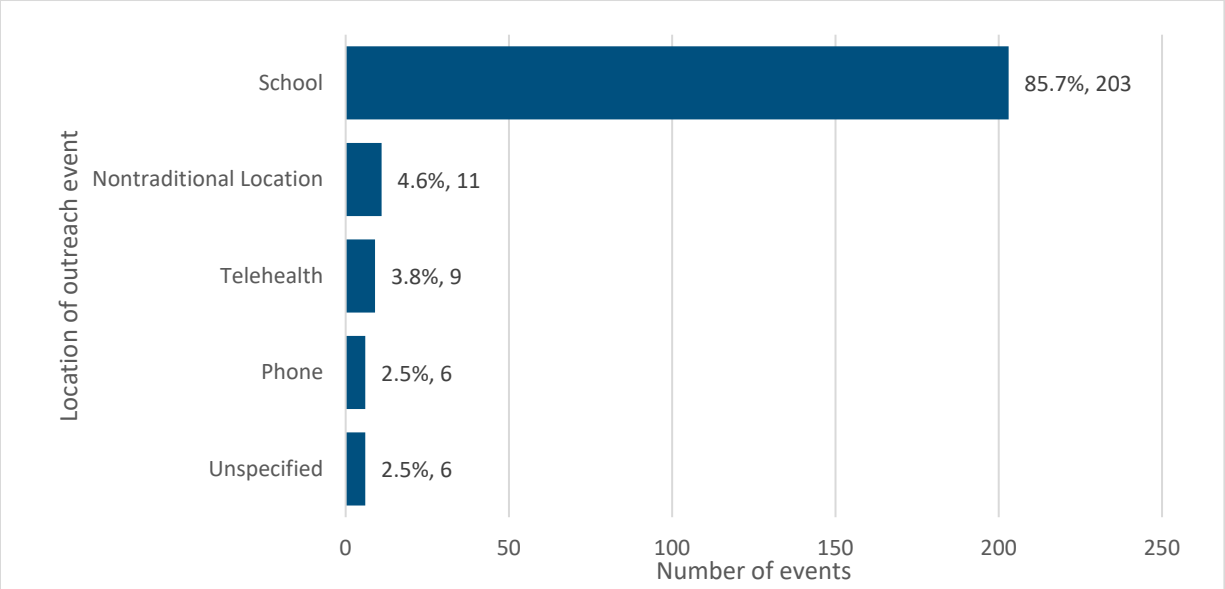
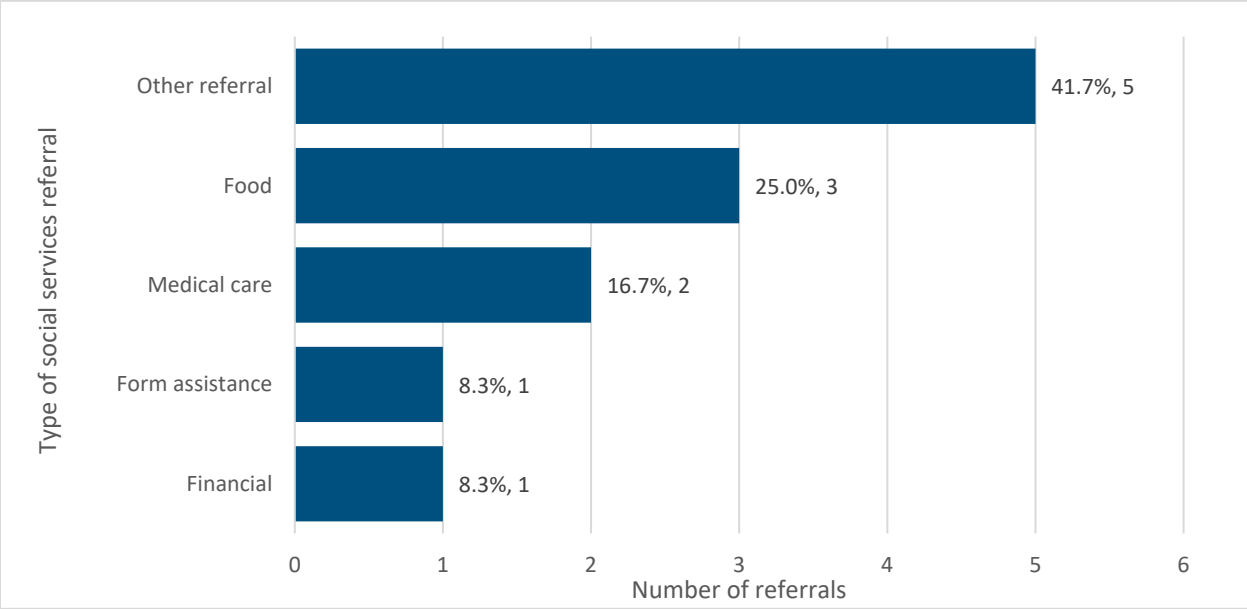


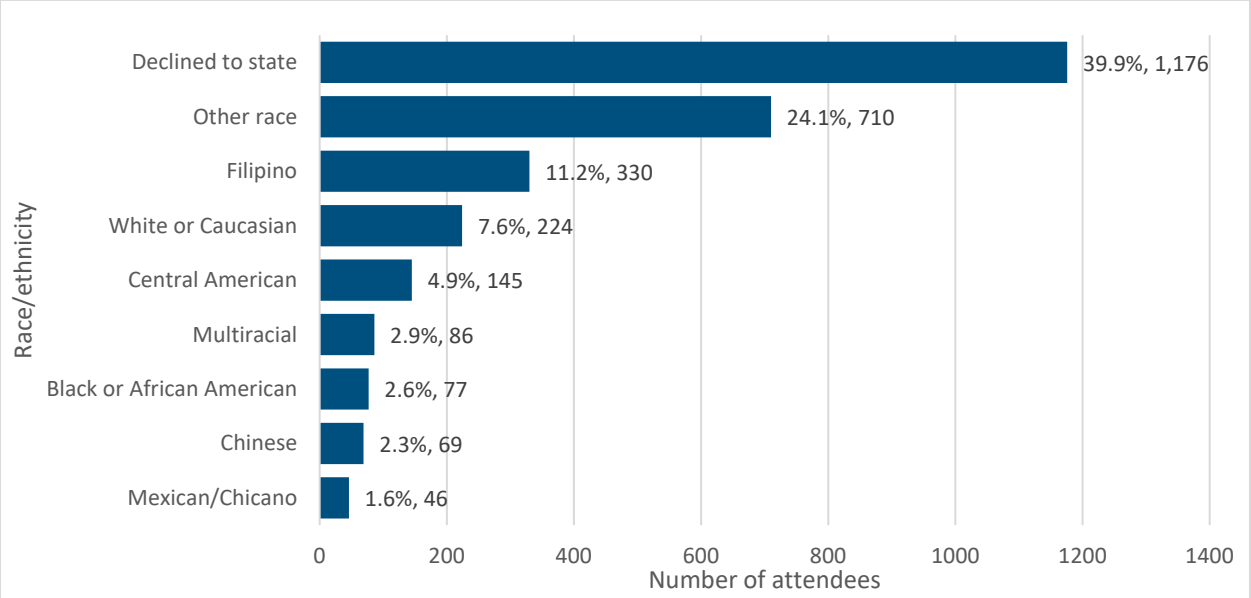
Exhibit D2. Daly City Youth Center Social Services Referrals, FY 2021–2022



Outreach event attendees

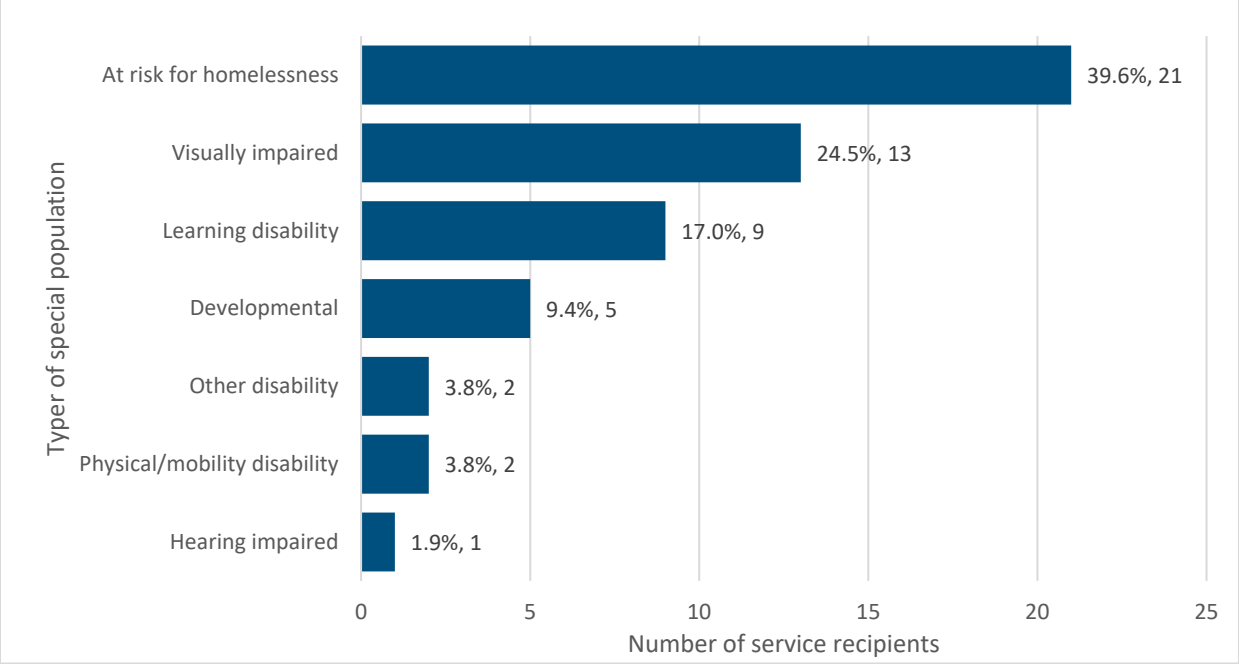
- Were female (**31.5%**, *n* = 923) and male (**26.5%**; *n* = 776). More than 40% of attendees declined to state their sex at birth (**41.9%;** *n* = 1,227).
- Identified their gender as female (**29.2%;** *n* = 851) or male (**25.4%**; *n* =7 41). Forty-three percent of attendees declined to state their gender (**43.1%;** *n* = 1,256).
- Identified as heterosexual (**30.0%;** *n* = 878), bisexual (**4.7%;** *n* = 137), questioning (**2.0%;** *n* = 58) gay/lesbian (**1.4%;** *n* = 41), and queer (**0.9%;** *n* = 26). Most declined to state their sexual orientation (**59.2%;** *n* = 1,732).
- Included children (15 years of age and younger; **45.7%**; *n* = 1,348), transition-age youth (16–25 years of age, **18.9%;** *n* = 557), and adults (26–59 years of age; **1.0%**; *n* = 30). The remaining attendees (**34.4%;** *n* = 1,014) declined to state their age.
- Declined to state their race (**39.9%**; *n* = 1,176). The remaining attendees were another race (**24.1%;** *n* = 710), Filipino (**11.2%;** *n* = 330), White (**7.6%;** *n* = 224), or Central American (**4.9%;** *n* = 145). (See **Exhibit D3**.)

Exhibit D3. Daly City Youth Center Attendees by Top Racial/Ethnic Category, FY 2021–2022



In FY 2021–2022, Daly City Youth Center attendees reported being in special population groups. Among recipients in the special population groups, **39.6%** were at risk for homelessness, **24.5%** were visually impaired, and **17%** had a learning disability. (See **Exhibit D.**) They also reported having a developmental disability, another disability, or a physical/mobility disability, or being hearing impaired.

Exhibit D4. Daly City Youth Center Service Recipients by Special Populations, FY 2021–2022



Appendix E. FY 2021–2022 Outreach, El Concilio

For FY 2021–2022, El Concilio reported 149 outreach events, all of which were individual events. There were 149 attendees. Individual outreach events lasted from 10 to 20 minutes and lasted 12 minutes on average.

Outreach events

- Most took place in an office (**51.0%**; *n* = 76). Other locations of events and their respective percentages are shown in **Exhibit E1**.
- Were conducted in Spanish (**91.9%**; *n* = 137), English (**7.4%;** *n* = 11), and Mandarin (0.7%; *n* = 1).
- Resulted in 26 mental health referrals and no substance use referrals at the individual outreach events.
- Resulted in 222 social services referrals. (See **Exhibit E2**.). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made primarily to other services (**43.7.%;** *n* = 98), form assistance (**26.1%;** *n* = 25), and legal assistance (**12.6%;** *n* = 28) services.

Exhibit E1. Locations of El Concilio Outreach Events, FY 2021–2022

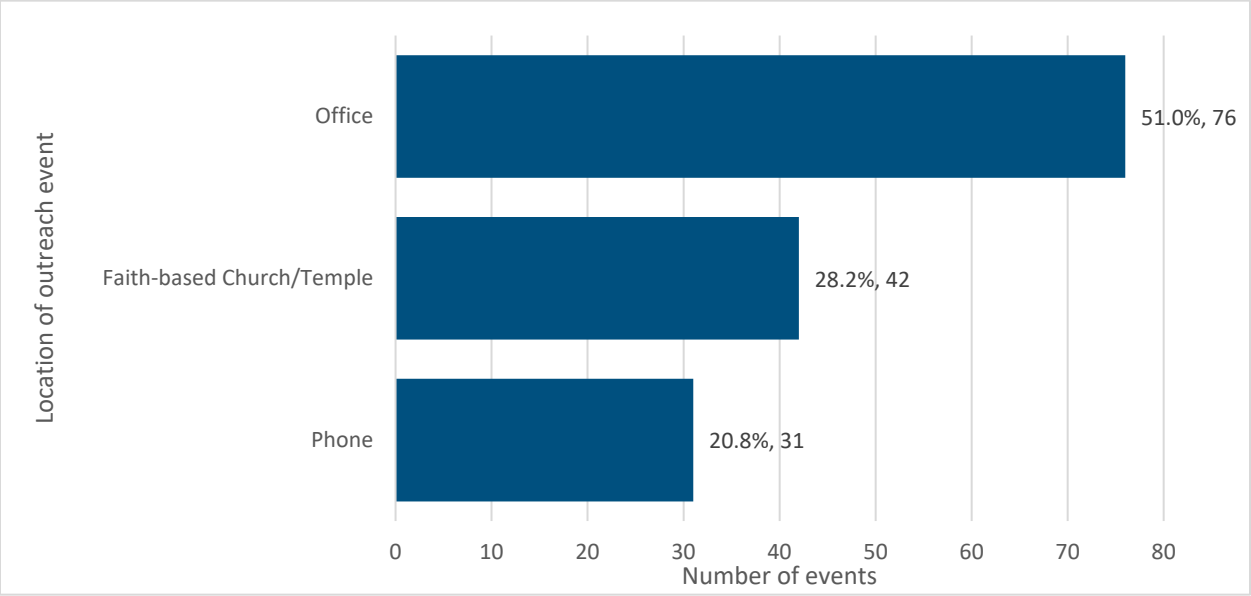
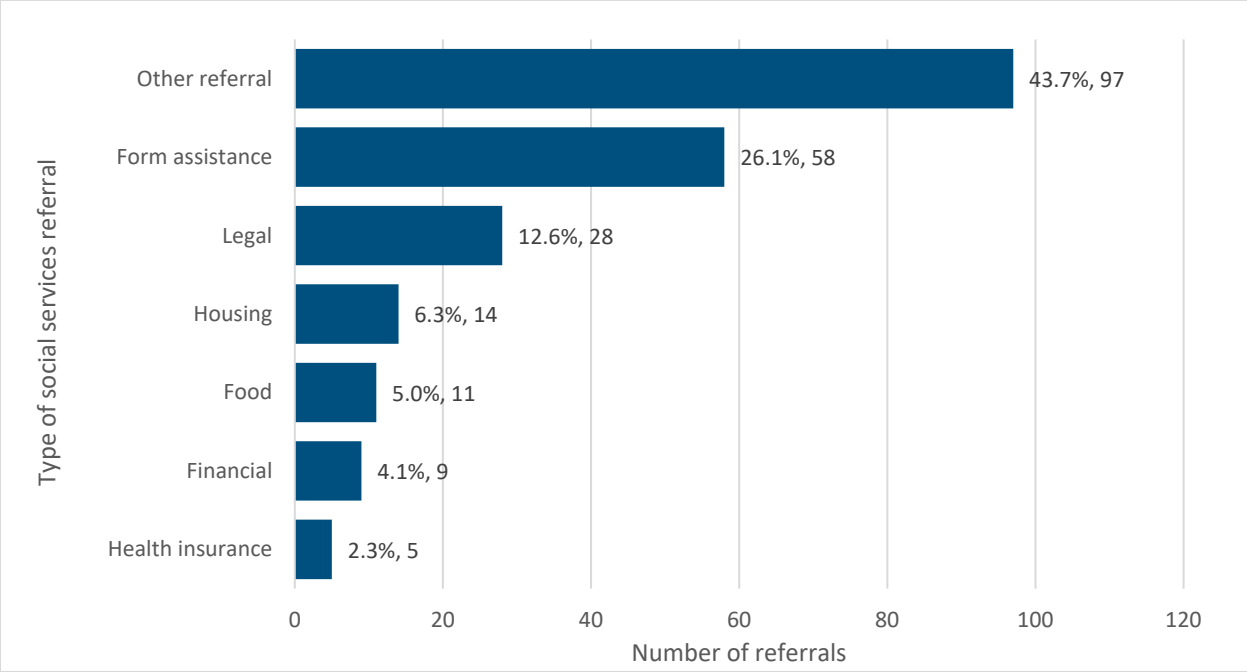


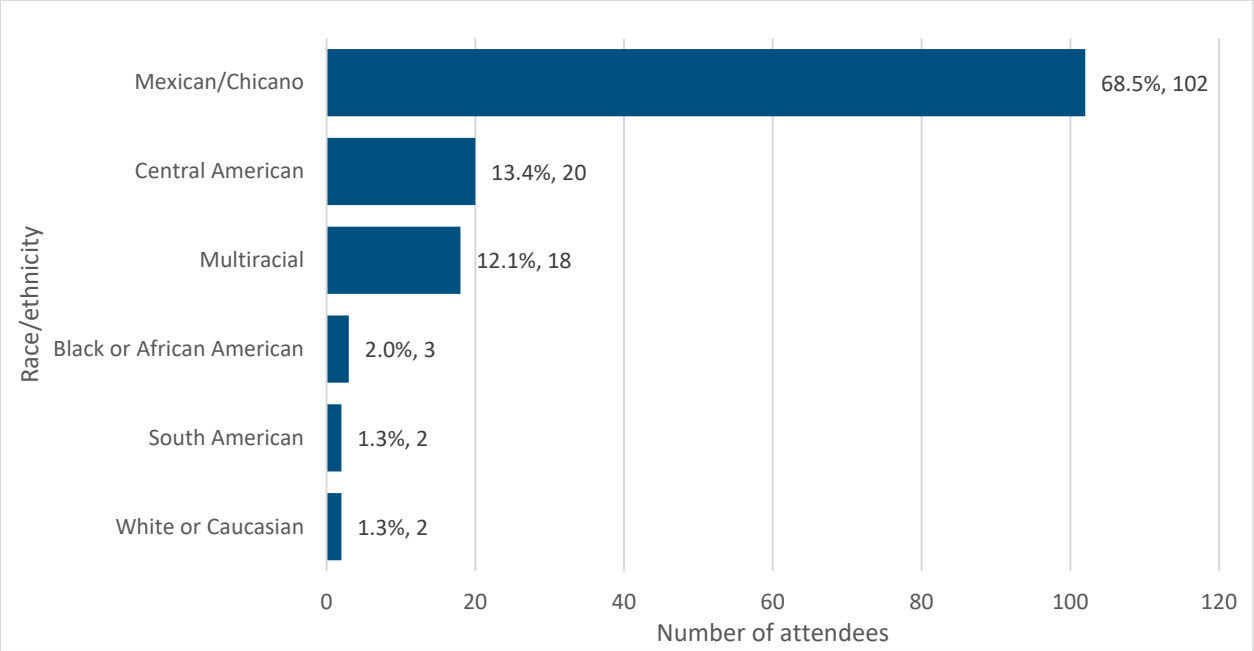
Exhibit E2. El Concilio Social Services Referrals, FY 2021–2022



Outreach event attendees

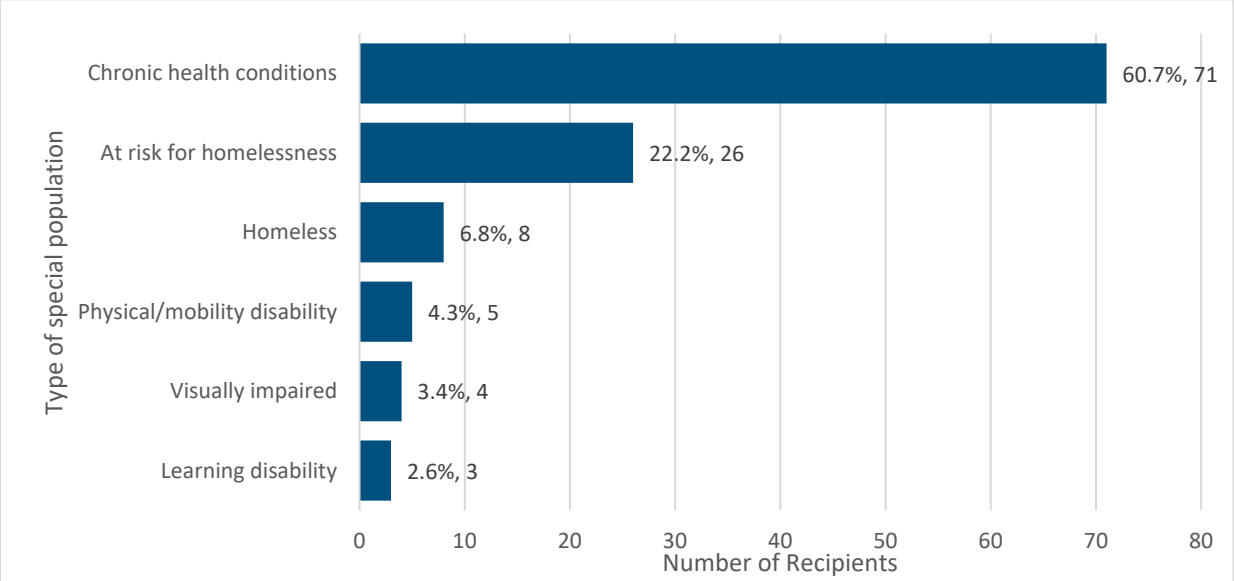
- Most often were female (**84.6%;** *n* = 126); 15% were male (**15.4%;** *n* = 23).
- Identified their gender as female (**79.9%;** *n* = 119), male (**18.8%;** *n* = 28), and male-to-female transgender (1.3%; *n* = 2).
- Were heterosexual (**98.7%;** *n* = 147) or gay/lesbian (**1.3%;** *n* = 2).
- Included adults (26–59 years of age, **77.9%;** *n* = 116), older adults (60 years, **17.4%;** *n* = 26), and transition-age youth (16–25 years of age, **4.0%;** *n* = 6).
- Were Mexican (**68.5%;** *n* = 102), Central American (**13.4%;** *n* = 20), or more than one race (**12.1%;** *n* = 18). (See **Exhibit E3.**)

Exhibit E3. El Concilio Attendees by Top Racial/Ethnic Category, FY 2021–2022



In FY 2021–2022, El Concilio attendees reported being in special population groups. Among service recipients in special population groups, **60.7%** had chronic health conditions, **22.2%** were at risk for homelessness, and **56.8%** were homeless. (See **Exhibit E4**.) They also reported having a physical/mobility disability, being visually impaired, or having a learning disability.

Exhibit E4. El Concilio Service Recipients by Special Populations, FY 2021–2022



Appendix F. FY 2021–2022 Outreach, Free At Last

For FY 2021–2022, Free At Last reported 171 outreach events, all of which were individual events. There were 171 attendees. The events lasted from 10 to 30 minutes and were 14 minutes on average.

Outreach events

- Most frequently took place over the phone (**88.9%;** *n* = 152). Events also took place in an office (**11.1%;** *n* = 19) as shown in **Exhibit F1.**
- Were conducted in English (**49.7%;** *n* = 85), Spanish (**49.7%;** *n* = 85), and Mandarin (**0.6%;** *n* = 1).
- Resulted in 19 mental health referrals and 138 substance use referrals at the individual outreach events.
- Resulted in 330 social services referrals. (See **Exhibit F2**.) An *individual* outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were primarily made to medical care (**33.3%;** *n* = 37), housing (**49.5%;** *n* = 55), health insurance (**3.0%;** *n* = 10), and legal referrals (**1.5%;** *n* = 5).

Exhibit F1. Locations of Free At Last Outreach Events, FY 2021–2022

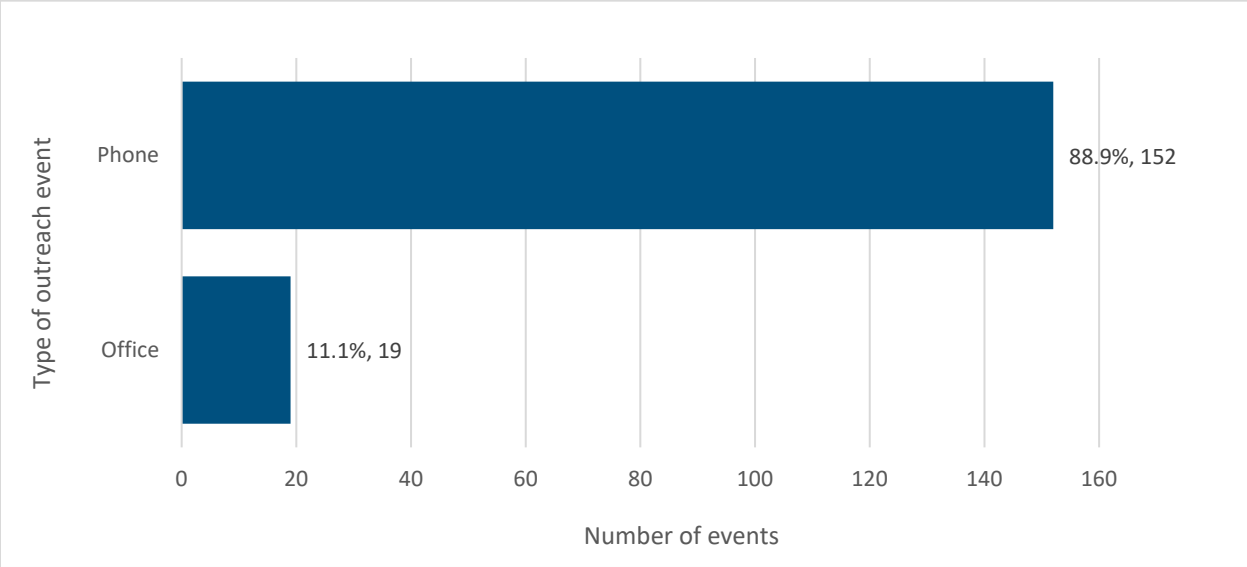
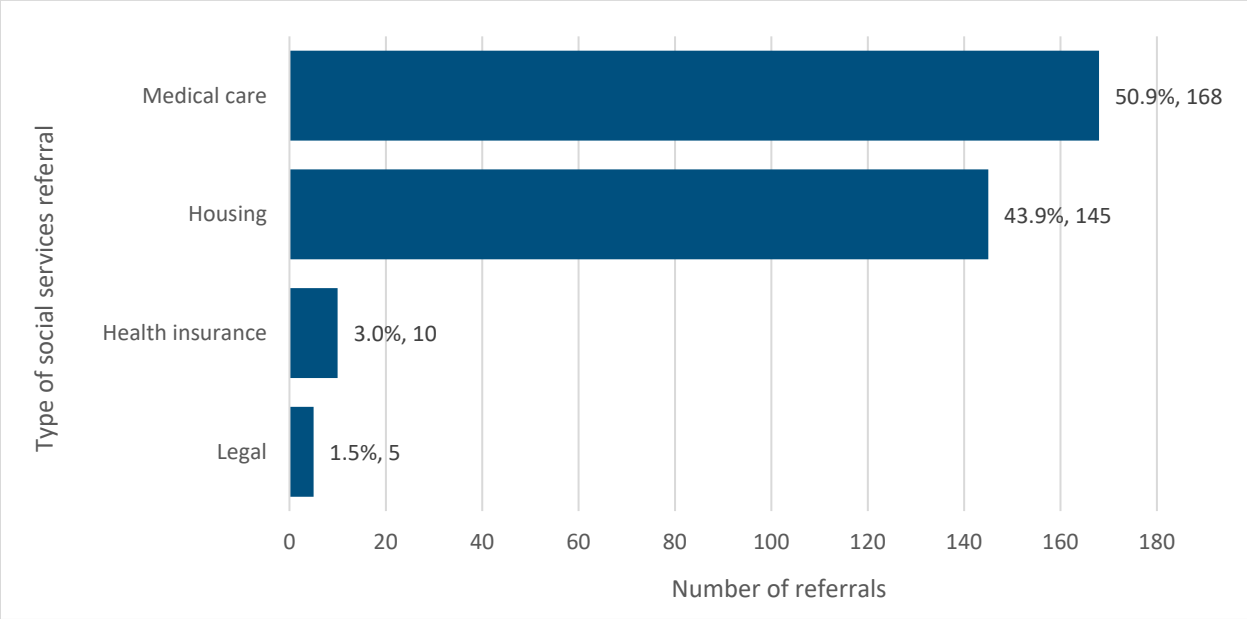


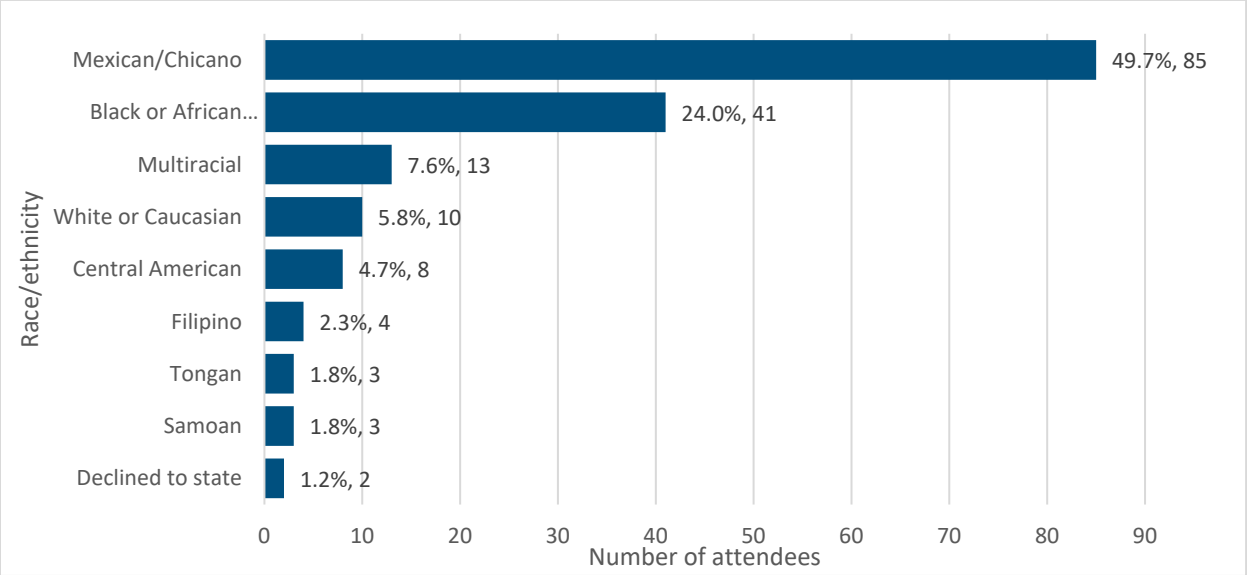
Exhibit F2. Free at Last Social Services Referrals, FY 2021–2022



Outreach event attendees

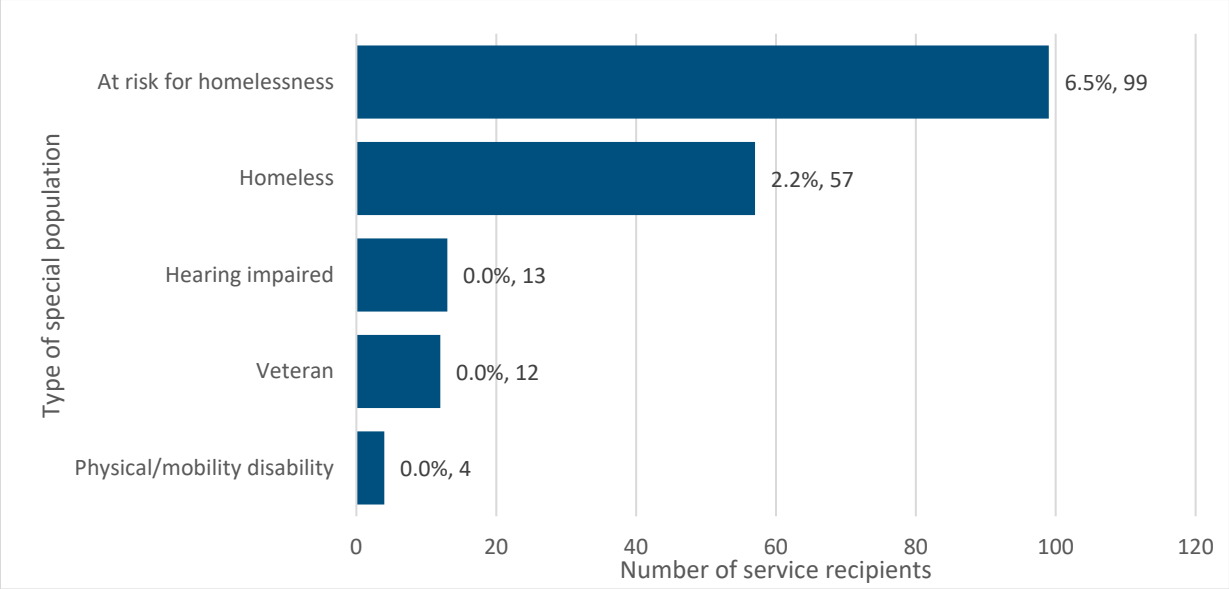
- Most often were male (**60.5%;** *n* = 104); 39% were female (**39.0%;** *n* = 67).
- Identified their gender as male most of the time (**58.4%;** *n* = 101); 39% identified as female (**39.3%;** *n* = 68). Three attendees identified as male-to-female transgender (1.7%) and one attendee as female-to-male transgender (0.6%).
- Identified as heterosexual (**59.4%;** *n* = 114), bisexual (**20.8%;** *n* = 40), gay/lesbian (**15.1%;** *n* = 29), or pansexual (4.7%; *n* = 9).
- Included adults (26–59 years of age, **81.3%;** *n* = 139) and transition-age youth (16–25 years of age, **18.7%;** *n* = 32).
- Were Mexican (**49.7%;** *n* = 85), Black (**24.0%;** *n* = 41), or more than one race (**7.6%;** *n* = 13). (See **Exhibit F3**.)

Exhibit F3. Free at Last Attendees by Top Racial/Ethnic Category, FY 2021–2022



In FY 2021–2022, Free At Last attendees reported being in special population groups. Among service recipients in special population groups, **53.5%** were at risk for homelessness and **30.8%%** were homeless. (See **Exhibit F4**.) They also reported being hearing impaired, veterans, or having a physical/mobility disability.

Exhibit F4. Free At Last Service Recipients by Special Populations, FY 2021–2022



Appendix G. FY 2021–2022 Outreach, Pacifica Collaborative

For FY 2021–2022, Pacifica Collaborative reported 26 outreach events, including 14 individual outreach events and 12 group outreach events. There were 3,221 attendees. Individual outreach events lasted an average of 34 minutes. Group outreach events lasted from 90 to 180 minutes and lasted an average of 115 minutes.

Outreach events

- Most frequently took place at another community location (**50.0%;** *n* = 13). Other locations for events and their respective percentages are shown in **Exhibit G1.**
- Were conducted in English (**100.0%;** *n* = 26).
- Resulted in 12 mental health referrals and 7 substance use referrals.
- Resulted in 33 social services referrals. (See **Exhibit G2**). An individual outreach event can have more than one referral, so the total number of other referrals exceeds the number of outreach events. Referrals were made primarily to food (**30.3%;** *n* = 10) and housing (**21.2%;** *n* = 7) assistance services.

Exhibit G1. Locations of Pacifica Collaborative Outreach Events, FY 2021–2022

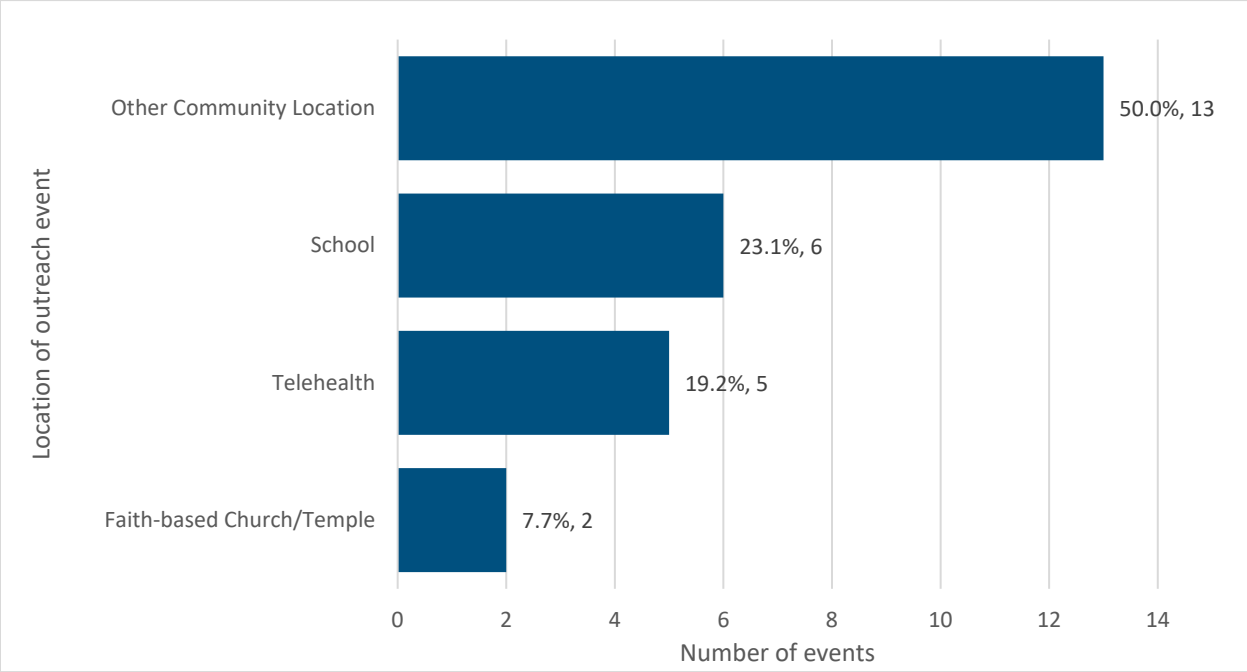
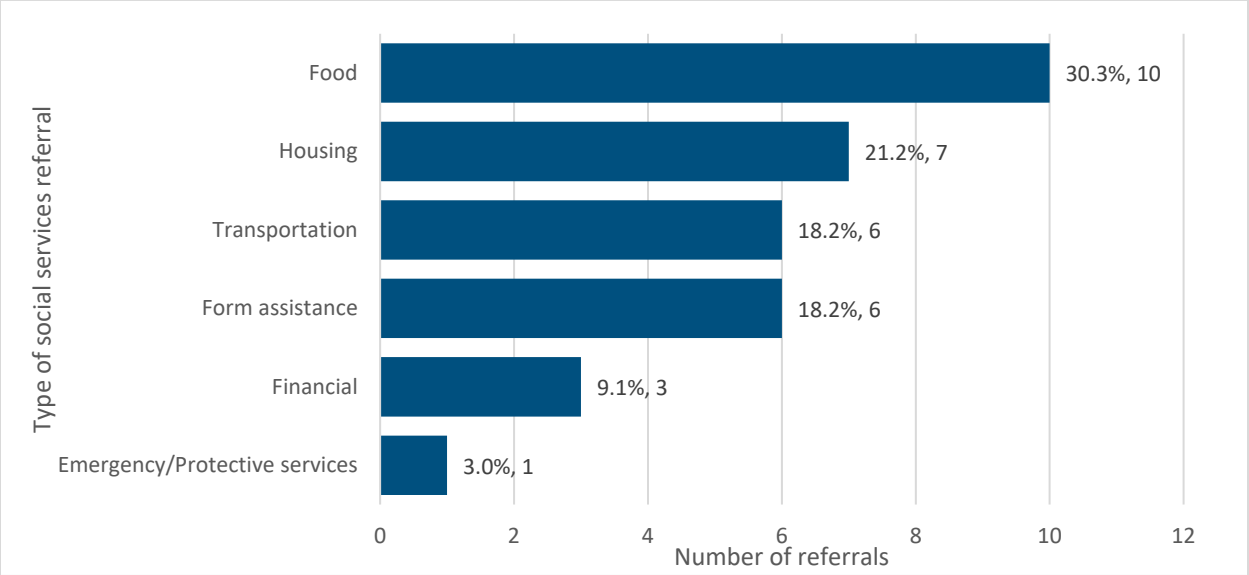


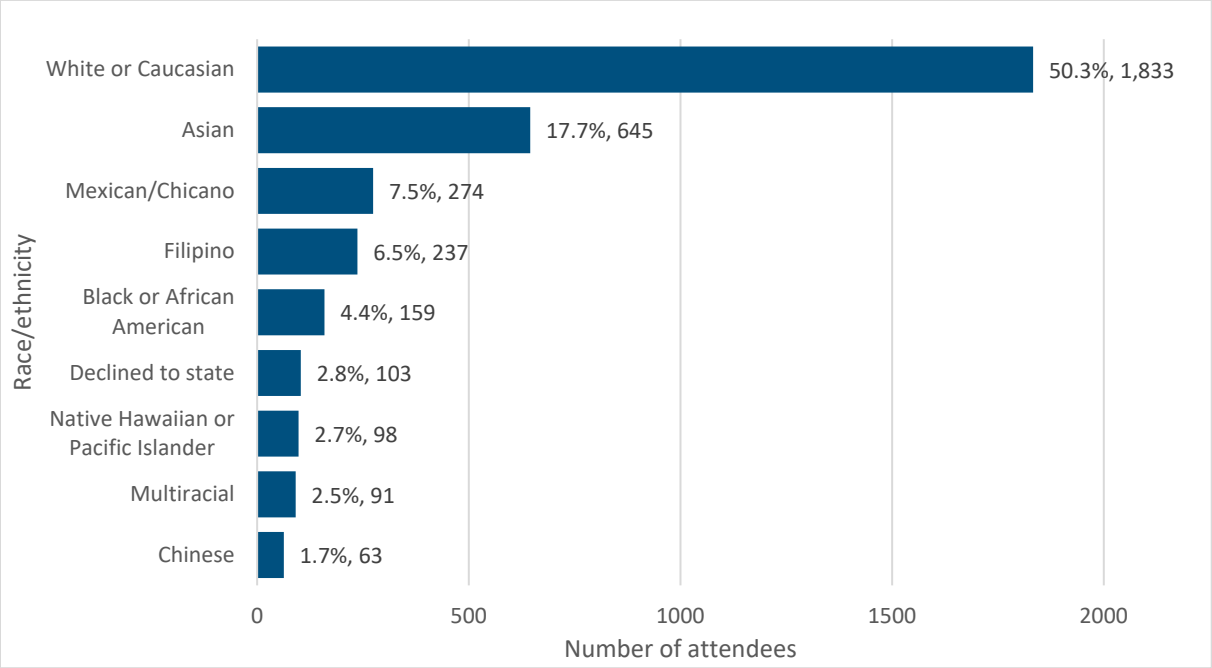
Exhibit G2. Pacifica Collaborative Social Services Referrals, FY 2021–2022



Outreach event attendees

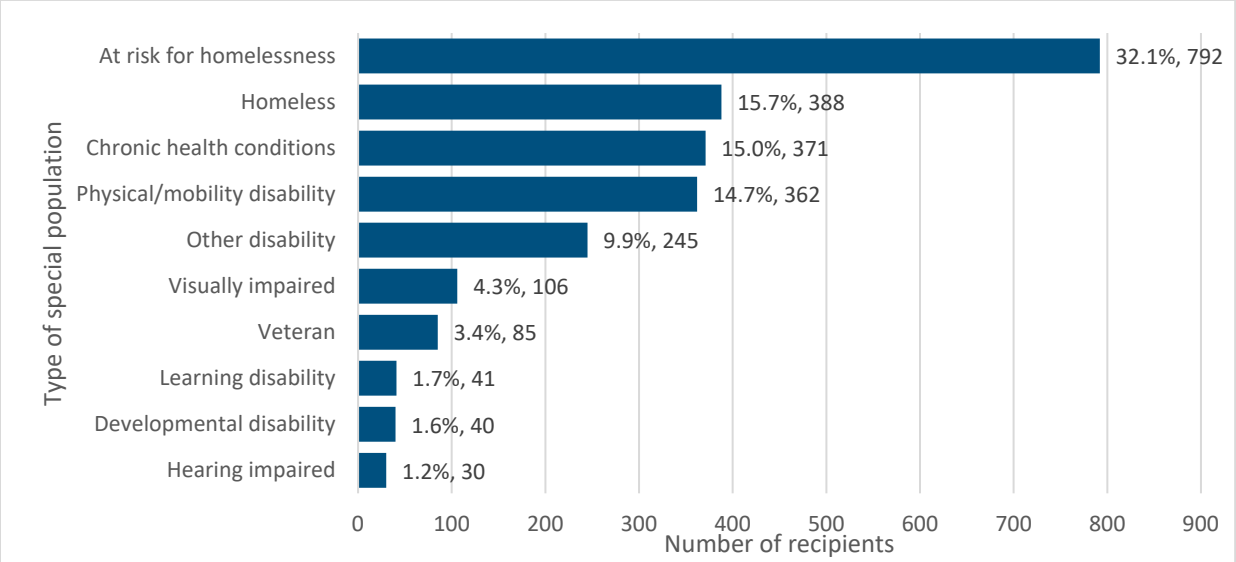
- Were female (**55.3%;** *n* = 1,781) or male (**40.5%;** *n* = 1,306). There were 134 (**4.2%**) individuals who declined to state their sex at birth.
- Identified their gender as female (**55.6%;** *n* = 1,789) or male (**40.5%;** *n* = 1,305). There were 123 (**3.8%**) attendees who declined to state their gender.
- Identified as heterosexual (**68.3%;** *n* = 2,201), gay/lesbian (**4.9%;** *n* = 159), bisexual (**4.5%;** *n* = 146), or questioning (**0.4%;** *n* = 14). More than **20%** of attendees (*n* = 699) declined to state their sexual orientation.
- Included adults (26–59 years of age, **32.9%;** *n* = 1,059) and older adults (60 years of age and older, **27.3%**; *n* = 878). Outreach event attendees also included transition-age youth (16–25 years of age, **18.0%;** *n* = 580) as well as children and teens (0–15 years of age, **13.7%**; *n* = 442) The age of **8.1%** (*n* = 262) of participants was unknown.
- Were White (**50.3%;** *n* = 1,833) or Asian (**17.7%;** *n* = 645). (See **Exhibit G3**.)

Exhibit G3. Pacifica Collaborative Attendees by Top Racial/Ethnic Category, FY 2021–2022



In FY 2021–2022, Pacifica Collaborative attendees reported being in special population groups. Among service recipients in the special population groups, **32.1%** were at risk for homelessness, **15.7%** were homeless, and **15.0%** had chronic health conditions. (See **Exhibit G4**.) They also reported having a physical/mobility disability, or another disability, being visually impaired, being a veteran, having a learning disability, having a developmental disability, and being hearing impaired.

Exhibit G4. Pacifica Collaborative Service Recipients by Special Populations, FY 2021–2022



Appendix H. FY 2021–2022 Outreach, StarVista

For FY 2021–2022, StarVista reported four outreach events, all of which were group outreach events. There were 26 attendees. Outreach events lasted 90 minutes on average.

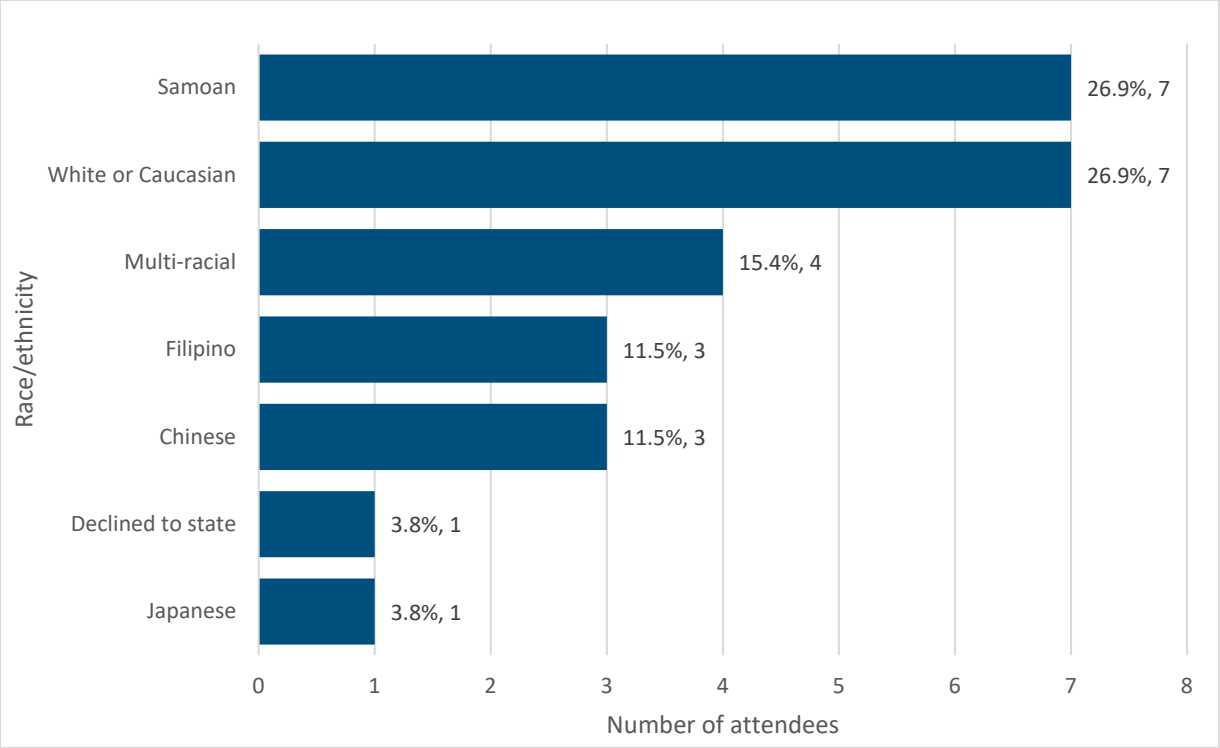
Outreach events

- 100% took place via telehealth (*n* = 4).
- Were conducted in English (**100%;** *n* = 4).
- Did not result in any mental health or substance use referrals.
- Did not result in any social services referrals in FY 2021–2022.

Outreach event attendees

- Were female (**65.4%;** *n* = 17) or did not indicate their sex at birth (**34.6%;** *n* = 9).
- Identified their gender as female (**73.1%**; *n* = 19) or did not indicate their gender (**26.9%;** *n* = 7).
- Identified as heterosexual (**23.1%;** *n* = 6) or did not indicate their sexual orientation (**76.9%**; *n* = 20).
- Were adults (26–59 years of age, **23.1%;** *n* = 6) or did not indicate their age (**76.9%;** *n* = 20).
- Were Samoan (**26.9%;** *n* = 7), White (**26.9%;** *n* = 35), or more than one race (**15.4%;** 4). (See **Exhibit H3**.)

Exhibit H1. StarVista Attendees by Top Racial/Ethnic Category, FY 2021–2022



In FY 2021–2022, StarVista attendees did not report being in special population groups.

Appendix I. Attendees by Race/Ethnicity by Collaborative, FY 2017–2021

Exhibit I1. Attendees by Race/Ethnicity by Collaborative, FY 2017-2021

	EPAPMHO					NCOC				
Race/Ethnicity	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**
Black	200 (36.5%)	152 (23.2%)	93 (17.9%)	29 (11.8%)	44 (11.5%)	249 (3.1%)	167 (3%)	685 (5.4%)	202 (2.6%)	277 (3.4%)
White	47 (8.6%)	55 (8.4%)	18 (3.5%)	12 (4.9%)	12 (3.1%)	1981 (24.8%)	1484 (27%)	2024 (16%)	2336 (29.6%)	2394 (29.8%)
American Indian	1 (.2%)	2 (.3%)	1 (.2%)	0 (0%)	0 (0%)	67 (.8%)	56 (1%)	90 (.7%)	67 (.8%)	46 (.6%)
Middle Eastern	0 (0%)	0 (0%)	2 (.4%)	0 (0%)	0 (0%)	114 (1.4%)	28 (.5%)	44 (.3%)	30 (.4%)	28 (.3%)
Eastern European	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	12 (.2%)	2 (0%)	5 (0%)	1 (0%)	1 (0%)
European	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	8 (.1%)	21 (.4%)	5 (0%)	3 (0%)	1 (0%)
Mexican	53 (9.7%)	156 (23.8%)	119 (22.8%)	101 (41.2%)	187 (48.7%)	816 (10.2%)	462 (8.4%)	2302 (18.2%)	1235 (15.6%)	510 (6.3%)
Puerto Rican	1 (.2%)	2 (.3%)	2 (.4%)	1 (.4%)	1 (.3%)	4 (.1%)	10 (.2%)	44 (.3%)	36 (.5%)	2 (0%)
Cuban	0 (0%)	1 (.2%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Central American	7 (1.3%)	12 (1.8%)	19 (3.6%)	15 (6.1%)	28 (7.3%)	471 (5.9%)	32 (.6%)	127 (1%)	13 (.2%)	160 (2%)
South American	1 (.2%)	1 (.2%)	0 (0%)	1 (.4%)	2 (.5%)	51 (.6%)	15 (.3%)	27 (.2%)	67 (.8%)	6 (.1%)
Caribbean	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (0%)	0 (0%)	5 (0%)	0 (0%)	0 (0%)
Other Latino	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Asian	0 (0%)	0 (0%)	1 (.2%)	1 (.4%)	0 (0%)	1025 (12.8%)	550 (10%)	873 (6.9%)	604 (7.6%)	647 (8.1%)
Filipino	8 (1.5%)	9 (1.4%)	4 (.8%)	0 (0%)	4 (1%)	1000 (12.5%)	331 (6%)	1170 (9.3%)	316 (4%)	753 (9.4%)
Chinese	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	297 (3.7%)	212 (3.9%)	936 (7.4%)	304 (3.8%)	230 (2.9%)
Japanese	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	55 (.7%)	26 (.5%)	37 (.3%)	42 (.5%)	38 (.5%)
Korean	0 (0%)	0 (0%)	0 (0%)	1 (.4%)	1 (.3%)	34 (.4%)	12 (.2%)	39 (.3%)	25 (.3%)	7 (.1%)
South Asian	1 (.2%)	2 (.3%)	1 (.2%)	0 (0%)	0 (0%)	70 (.9%)	17 (.3%)	222 (1.8%)	50 (.6%)	52 (.6%)
Vietnamese	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	13 (.2%)	11 (.2%)	84 (.7%)	4 (.1%)	1 (0%)
Cambodian	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	8 (.1%)	2 (0%)	8 (.1%)	0 (0%)	0 (0%)
Laotian	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Mien	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Other Asian	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Tongan	88 (16.1%)	97 (14.8%)	30 (5.8%)	15 (6.1%)	35 (9.1%)	61 (.8%)	47 (.9%)	89 (.7%)	88 (1.1%)	118 (1.5%)
Samoan	35 (6.4%)	57 (8.7%)	26 (5%)	19 (7.8%)	31 (8.1%)	163 (2%)	201 (3.7%)	503 (4%)	137 (1.7%)	192 (2.4%)
Fijian	3 (.5%)	5 (.8%)	1 (.2%)	0 (0%)	4 (1%)	8 (.1%)	3 (.1%)	21 (.2%)	25 (.3%)	8 (.1%)
Hawaiian	5 (.9%)	15 (2.3%)	164 (31.5%)	40 (16.3%)	1 (.3%)	150 (1.9%)	188 (3.4%)	1521 (12.1%)	174 (2.2%)	127 (1.6%)
Guamanian	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	5 (.1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Multi	92 (16.8%)	86 (13.1%)	39 (7.5%)	9 (3.7%)	31 (8.1%)	407 (5.1%)	369 (6.7%)	1228 (9.7%)	248 (3.1%)	325 (4%)
Other Race	4 (.7%)	3 (.5%)	0 (0%)	1 (.4%)	0 (0%)	254 (3.2%)	140 (2.5%)	113 (.9%)	5 (.1%)	718 (8.9%)
Unknown Race	2 (.4%)	1 (.2%)	1 (.2%)	0 (0%)	2 (.5%)	671 (8.4%)	1106 (20.1%)	412 (3.3%)	1883 (23.8%)	1392 (17.3%)
Total	**548**	**656**	**521**	**245**	**384**	**7996**	**5492**	**12614**	**7899**	**8033**

Note. Percentages may not sum to 100% because of rounding. The total count for race/ethnicity reported may exceed the total number of attendees because some providers may have reported individuals who are multiracial as both multiracial and their respective race/ethnicity, leading to extra counts in some cases. The denominator for race/ethnicity percentage is the sum of all race/ethnicity data reported. N/A indicates the category was not available or discontinued during the specific fiscal year.

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19812_12/22

San Mateo County Behavioral Health and Recovery Services (SMC BHRS) Provider Outreach Efforts: The Barbara A. Mouton Multicultural Wellness Center

Fiscal Year 2021–2022

Koray Caglayan, PhD, Danielle Agraviador, MPH

DECEMBER 2022

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Contents

Exhibits

The Barbara A. Mouton Multicultural Wellness Center

For fiscal year (FY) 2021–2022, the Barbara A. Mouton Multicultural Wellness Center (the Mouton Center) reported 107 outreach events, all of which were individual events. Individual outreach events lasted 45 minutes on average.

Outreach events

- Most frequently took place in unspecified locations (**78.4%;** *n* = 29). Other event locations and their respective percentages are shown in **Exhibit 1**.
- Were conducted in English (**81.1%;** *n* = 30), Tongan (**16.2%;** *n* = 6), and Mandarin (**2.7%;** *n* = 1).
- Resulted in 35 mental health referrals and no substance use referrals.
- Resulted in one social service referral for medical care.

Outreach event attendees

- Most were female (**56.8%;** *n* = 21); 43% were male (**43.2%;** *n* = 16).
- Identified as female (**56.8%;** *n* = 21) or male (**43.2%;** *n* = 16).
- Identified as heterosexual (**97.3%;** *n* = 36) or queer (**2.7%;** *n* = 1).
- Were adults (26–59 years of age, **56.8%;** *n* = 21), older adults (60 years of age and older, **40.5%**; *n* = 15), or transition-age youth (16–25 years of age, **2.7%;** *n* = 1).
- Were primarily White (**40.5%;** *n* = 15), Tongan (**16.2%;** *n* = 6), or Asian (**16.2%;** *n* = 6). (See Exhibit 2).

Exhibit 1. Locations of Outreach Events, FY 2021–2022

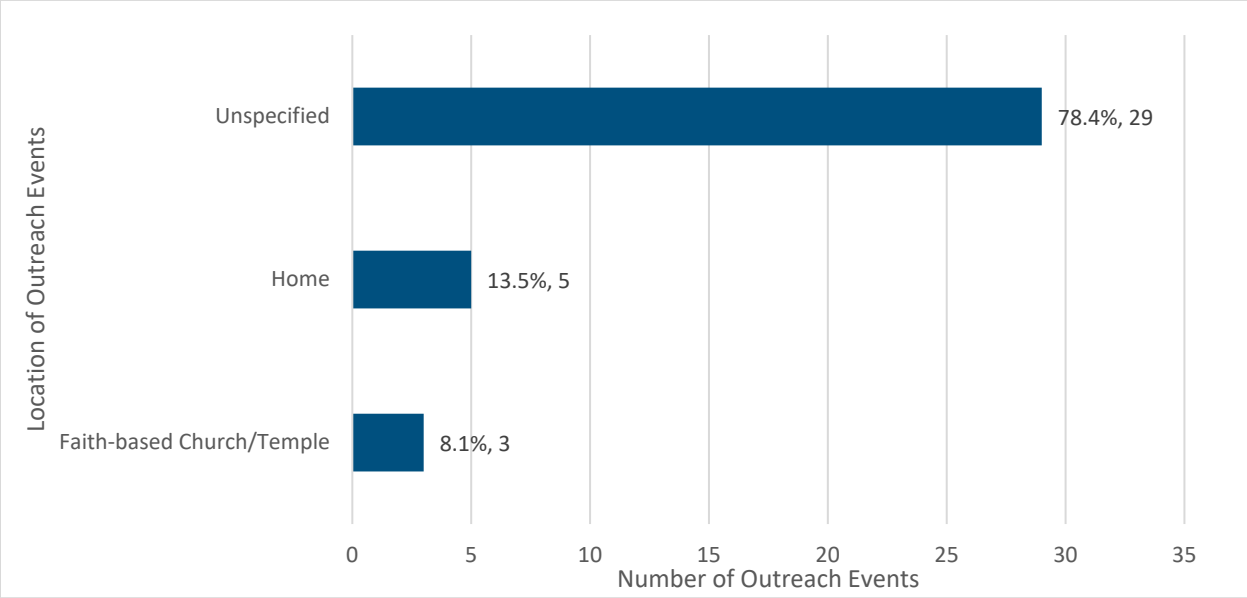
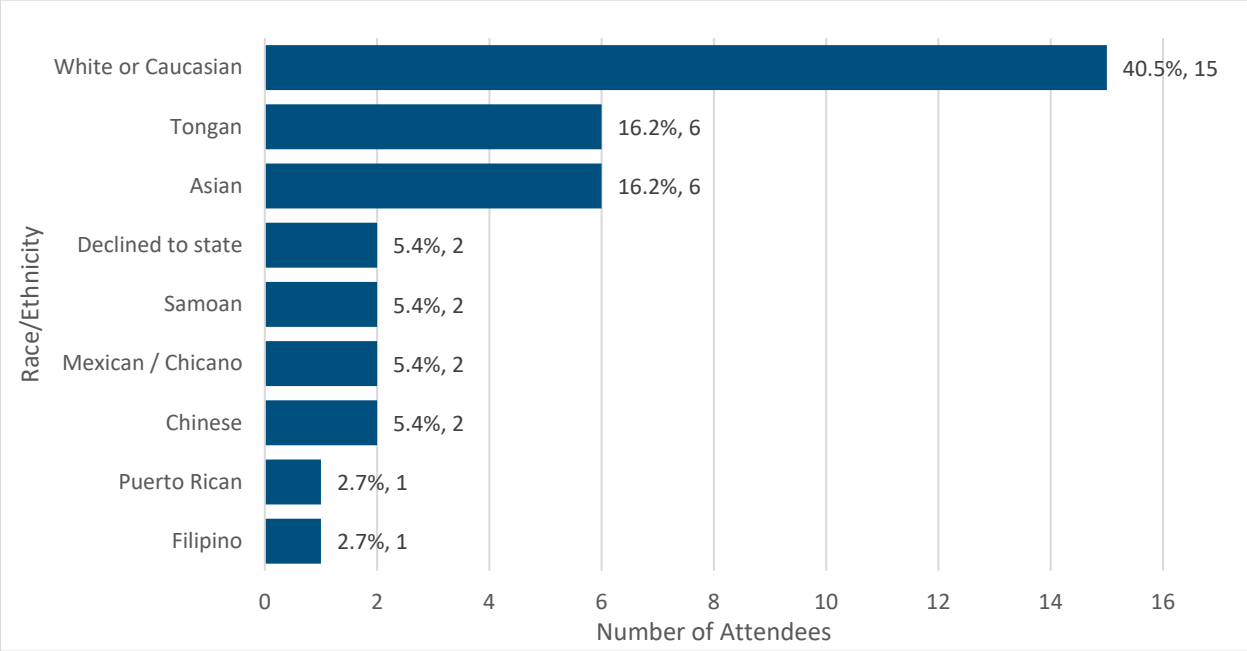


Exhibit 2. Attendees by Top Racial/Ethnic Category, FY 2021–2022



In FY 2021–2022, **three** attendees at the Mouton Center reported being in special population groups. Of the three service recipients in the special population group, one was at risk of homelessness, one had other chronic health conditions, and one had a physical/mobility disability.

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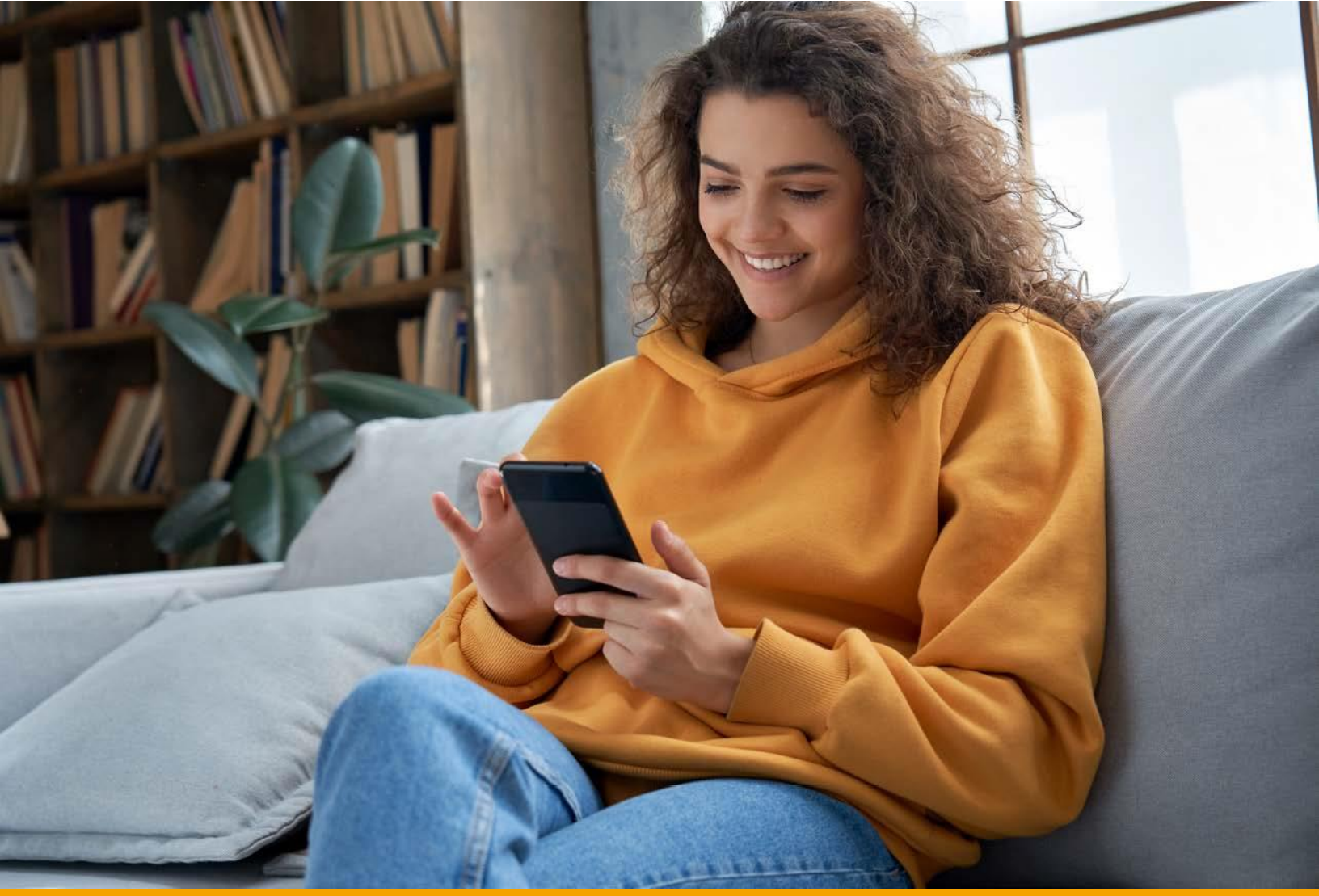
APPENDIX 10. HELP@HAND INN EVALUATION REPORT, FY 2021-22



San Mateo Help@Hand

MHSA INN Final Report

RDA CONSULTING

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

San Mateo Help@Hand

MHSA INN Final Report

This report was developed by Resource Development Associates under contract with San Mateo County Department of Behavioral Health and Recovery Services.

Resource Development Associates, 2022

RDA CONSULTING

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Table of Contents

Introduction

Help@Hand is a statewide Mental Health Services Act (MHSA) Innovation (INN) project that aims to bring technology-based solutions to county and city behavioral health systems. The project is administered by the California Mental Health Services Authority (CalMHSA) and funded and directed by local jurisdictions. San Mateo County Behavioral Health and Recovery Services (BHRS) identified the need for technology-based behavioral health supports as part of the fiscal year (FY) 2017-20 MHSA Three-Year Plan. In April and May of 2018, San Mateo conducted a Community Program Planning (CPP) process aimed to (1) inform community members about the proposed MHSA INN plan and (2) seek input and feedback from stakeholders to incorporate into the final plan. Stakeholders received background information about MHSA INN to ensure their ability to meaningfully participate.

Project Goals

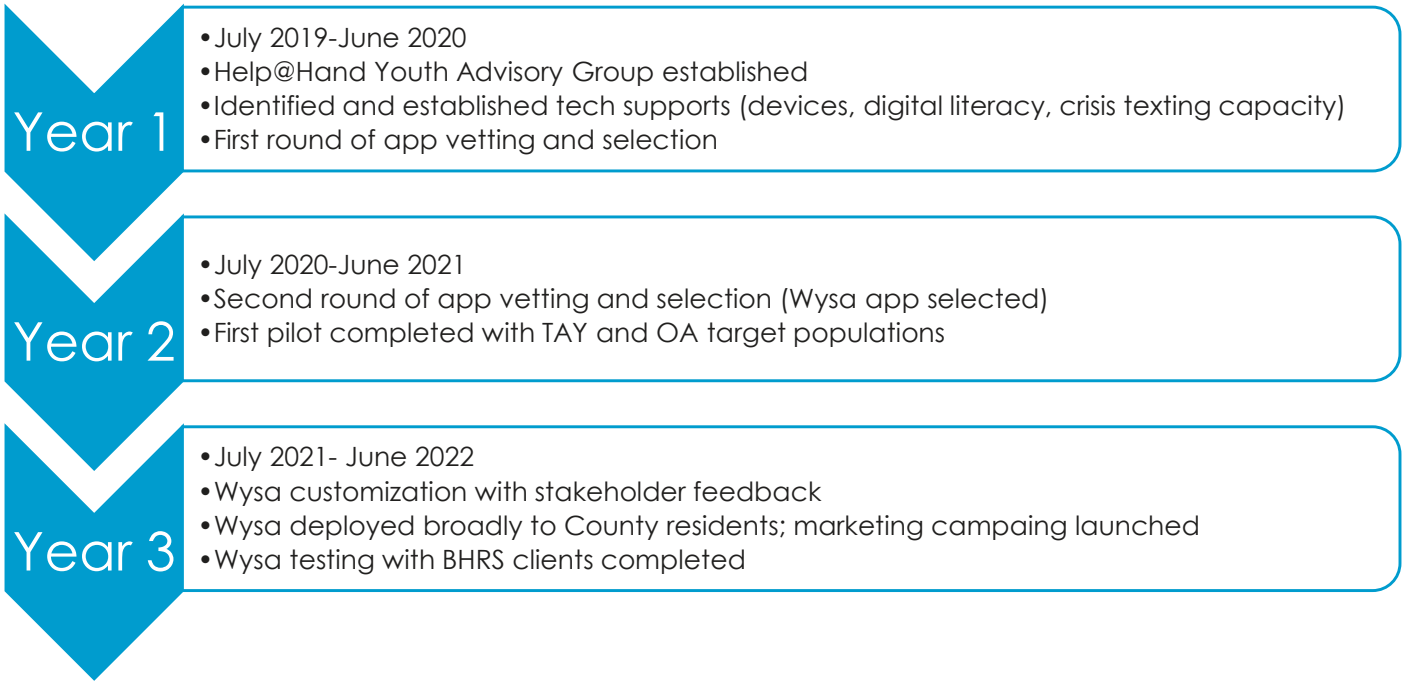
In San Mateo County, this INN project provided an opportunity for BHRS and its collaborative county partners to leverage technology, specifically behavioral health applications (apps), to reach and engage two priority populations, (1) transition age youth (TAY) and (2) older adults. Through the Help@Hand INN project, BHRS aims to:

- Provide access and linkages to behavioral health services
- Provide social connectivity through the use of virtual avatars and/or peers
- Support self-directed mental wellness and recovery goals

This project also serves to reduce the stigma associated with mental health treatment by using virtual engagement strategies and to provide alternative methods for engaging in behavioral health recovery and wellness activities.

Project Implementation

Figure 1. Summary Timeline of Tech-Based Solutions



The San Mateo Help@Hand project development was guided by a local Help@Hand Advisory Committee, which was established during the planning phase of the project and prior to the launch. The Help@Hand Advisory Committee was comprised of peers, family members of clients, and individuals from the older adult and TAY communities, BHRS staff, stakeholders from County departments (e.g., Information Technology, Aging and Adult Services), peer-based agencies California Clubhouse and Heart and Soul, and community-based agencies Peninsula Family Service and Youth Leadership Institute. Implementation highlights are summarized in the timeline above by year and further details are included as follows:

Year 1

The first part of year 1 included identifying needs to support the use of technology solutions in a behavioral health setting. The needs identified by the Help@Hand Advisory Committee resulted in establishing the following targeted supports:

1) Digital Mental Health Literacy (DMHL) train-the-trainer for Help@Hand peer staff that covered topics related to security and privacy measures and managing digital identity;
2) Get App-y Workshops for older adults to receive supports with basic 101 technology education and DMHL topics;
3) A Youth Advisory Group to guide priorities for Transition Age Youth; and

4) Expansion of the local crisis hotline to include text-based and social media supports in preparation for the app release.

While efforts to identify needs and establish supports began in year 1, this has been an ongoing and iterative process throughout the entire three-year timeline. The following additional tech supports were established in subsequent phases of the project to address emerging needs:

5) Technology device distribution, including data plans, for behavioral health clients and Help@Hand participants that do not have the resources to purchase technology;
6) Technology 101 trainings for BHRS peer staff that would be distributing devices; and
7) Tech Cafés or workshops for clients and the community at large to receive basic technology supports, DMHL education and advanced Zoom topics.

In the second half of year 1, Help@Hand stakeholders and contractors reviewed available technologies—which were approved through a Request for Statement of Qualifications (RFSQ) process led by CalMHSA—and participated in various app vetting, testing, and selection activities to identify the app they would like to pilot with the target populations. Through this first round, BHRS selected Happify as an app to move forward with older adult community piloting and Remente for TAY. At the onset of the COVID-19 pandemic, the Happify vendor terminated their participation in Help@Hand and TAY stakeholders recognized that the needs of the TAY population had changed. Both groups returned to the app vetting, selection and exploration process in the beginning of Year 2.

Year 2

In Year 2, as an immediate response to the COVID-19 pandemic, San Mateo County began two key activities:

1) Device Distribution: Lack of access to devices most prominently affects low-income, rural, disabled, people of color, and our older adult community, leading to a digital inequity. BHRS provided technology supports (devices and data plans), for one year, for clients and family members of clients that would benefit from telehealth and/or other behavioral health services but do not have the resources to purchase the technology needed. BHRS leveraged CARES Act funding to distribute 290 tablets with a one-year data plan to 15 BHRS contracted community agencies. MHSA funding was also leveraged to award 13 CBO's funding to procure devices, data plans, and accessories (hotspots, headphones, screen protectors, styluses, etc.) that support clients' use of the technology for behavioral health supports. MHSA funding was also allocated to purchase up to 790 devices for BHRS clients, including 30 tablets for residential Board and Cares and regional clinics. Staff, agencies, clients, community and faith leaders provided feedback that in addition to the lack of access to technology, many residents lacked the knowledge to use technology. This knowledge gap contributed to the digital divide. In response to this feedback, BHRS launched additional digital literacy supports including Technology 101 trainings, Tech Cafés and workshops for clients and the community. Training topics included:
    - How to set-up a Gmail account
    - Email maintenance
    - Professional emailing
    - Tips on how to scan a QR Reader
    - How to Download an Application (App)
    - Tips on using your phone camera
    - Online safety & privacy
    - Tips on Privacy Settings (mobile phone & social media)
    - Telehealth and telehealth etiquette
    - Zoom teleconferencing basics

2) Headspace Launch – the wellness app Headspace was made available to residents across the county including a Spanish version for Spanish-speaking populations. 3,245 San Mateo County residents downloaded and used Headspace. San Mateo County participated in a University of California, Irvine (UCI)-led evaluation of Headspace. Surveys were emailed to San Mateo County's Headspace users between July and October 2021. Over 300 (n=352) users responded to the baseline survey and 121 completed the follow-up survey. Key findings include:
    - Mental Health - 78% of respondents experienced mental health challenges. Current users scored higher on distress than abandoners.
    - Reasons for Not Using Headspace - Common reasons for abandoning Headspace were that people were using other strategies to support their mental health (32%) and/or they just wanted to try Headspace (31%).
    - Headspace Experience - Users had a positive experience with Headspace: 92% of Current users would recommend Headspace and 90% of Current users found Headspace easy to use. Among abandoners, 72% would recommend Headspace and 75% found it easy to use.
    - Mental Health Resources - Almost half of respondents had made use of resources other than Headspace, such as online tools and professional mental health resources, to support their mental health.

BHRS leveraged the launch of Headspace to conduct a second round of vetting and testing activities, although stakeholders ultimately selected Wysa as an app to move forward with for both older adults and TAY community piloting. A key factor in this decision was Wysa app developers' willingness to customize and refine the app to fit the needs and priorities of the local population. Additionally, both target populations viewed Wysa as more culturally relevant compared to the other apps explored. In the second half of Year 2, San Mateo County designed and implemented a pilot to define and measure success with the selected Wysa app and inform app customizations and a broad deployment plan. After a successful app pilot, the product and pilot outcomes were presented to Help@Hand Leadership and Wysa was included in the Help@Hand technology portfolio, thereby allowing other jurisdictions to more easily integrate the apps into their behavioral health systems.

Furthermore, BHRS began working with the app developers to customize what the Help@Hand Advisory Committee recommended as mandatory customizations in order to ensure success of the app. The mandatory recommendations included the following:

- Create instructions/tutorials for accessing and using the app.
- Include a disclaimer about the chatbot and the app's intended purpose, "the app is a light touch resource for wellness concerns, not a replacement for therapy."
- Update the notifications and reminders to be more motivating and engaging for TAY users.
- Include an in-app directory/search function that allows users to quickly navigate to what they need within the app.
- Remove all mentions of the ask-a-therapist feature; this was a high risk assessment issue.
- Create more topics specific to the needs of TAY and Older Adults.
- Update the SOS button name to reflect the page content and/or add local resources. .

See attached Spotlight on San Mateo County's Wysa Pilot.

Year 3

In Year 3, the County launched the customized app to the two identified target populations (older adults and TAY). BHRS contracted with Uptown Solutions to develop a marketing campaign and advertised the availability of Wysa to residents through a landing page, hosted by CalMHSA, a partner toolkit distributed to over 2,000 BHRS agency partners and stakeholders, which included flyers and social media posts to share, digital ads, organic social media posts, transit ads on 30 buses throughout the

county, mailing of 10,000 postcards to targeted residents, and print/media ads with the Daily Journal. See attached San Mateo County Marketing Campaign Report.

RDA conducted a brief survey of early users (who downloaded the app through August 2022 and after the first two months after the marketing campaign roll out.) to further assess the impact of the app and inform the Innovation Learning Goals.

Simultaneously, BHRS, stakeholders and contractors reviewed the results of the pilot stage and decided to further test the app with behavioral health clients to determine if the app could support clients in between therapy appointments with their wellness and recovery goals and if the app could be integrated into their system of care.

The table below provides a comprehensive timeline of activities and major events that occurred over the three-year project timeline.

Table 1. San Mateo Help@Hand Timeline of Activities

Dates	Activities
Year 1	**Identifying needs and establish targeted supports**
July 2019	○ Peninsula Family Services (PFS)[1] and Youth Leadership Institute (YLI)[2] fully onboarded and begin developing focus groups with target populations to identify needs and peer-led outreach strategies; ○ Contracted StarVista to develop texting and social media supports for youth in crisis to expand resources for wellness app users ○ CalMHSA facilitated focus groups in San Mateo to develop digital health literacy curriculum
August 2019	○ Get App-y Workshops launch to support older adults in basic technology 101 and the development of the H@H Youth Advisory Group.
Sept. – Oct. 2019	○ Identified need to research additional tech solutions

[1] YLI is the contracted organization to conduct peer-led outreach to the TAY population for the Help@Hand project.
[2] PFS is the contracted organization to conduct peer-led outreach to the older adult population for the Help@Hand project.

	○ CalMHSA facilitated a second RFSQ process to broaden the pool of possible tech solutions; this resulted in 93 solutions to choose from
Nov. 2019 – Jan. 2020	○ Completed first round of App demos, vetting and selection process included local focus groups with TAY and OA
Jan. 2020	○ App exploration training to identify customization needs and inform app deployment needs. We selected Happify for older adults and Remente for TAY for the pilot phase
Feb. – April 2020	○ COVID-19 led to Happify vendor backing out of the project and TAY stakeholders recognized that the needs of the population had changed. Both groups returned to the app vetting, selection and exploration process
May 2020	○ Device procurement and deployment pilot begins with peer-led agencies California Clubhouse and Heart & Soul
Year 2	**App demonstrations vetting and selection**
July – Oct. 2020	○ Second round of App demos, vetting and selection process included local focus groups with TAY and older adults; Wysa app selected, began pilot proposal development
Sept. 2020	○ Purchased 10,000 Headspace app licenses and distributed them rapidly to support SMC community mental health wellness during COVID-19
Oct. 2020	○ Contracted with Painted Brain to provide tech 101 trainings for peer staff that would be distributing devices and Tech Cafés for clients and the community at large
Nov. – Dec. 2020	○ Launched distribution of 250 tablets to network of providers, 50 tablets to Board and Cares and clinic sites, funding for 700+ devices for BHRS clients plus device accessories needed for engagement (headphones, covers, styluses, hotspots, etc.)
April – June 2021	○ Launched Pilot with TAY and older adults to further test the selected app Wysa
May 2021	○ Began exploration of needs for integration into BHRS system of care ○ Decided to wait until after the local customizations are completed and broad deployment of the app begins.
Year 3	**App pilot implementation, and analysis**
June 2021	○ Added advanced Zoom topics to Painted Brain's contract. Held first training to address equitable practices while facilitating Zoom meetings
July-Aug 2021	○ Headspace Survey and results from UCI ○ Pilot with TAY and older adults continued
Oct-Dec 2021	○ Purchased licenses for Wysa and completed marketing contracts
Jan-Feb 2022	○ Wysa app customizations completed with input from Advisory Committee
March-April 2022	○ App launched, supported by peer-led outreach from community partners (YLI and PFS) ○ Launched further app testing with Adult BHRS clients
May-June 2022	○ Completed sustainability planning ○ Developed and launched communications plan for app deployment

Evaluation Overview

The County contracted Resource Development Associates (RDA) to evaluate this project over a three-year period (from 2019-2022.) The following locally defined Learning Goals evolved over the course of the project and were established by the Help@Hand Advisory Committee:

Learning Goal 1

Can a mental health app connect transition age youth and older adults to mental health services and other supports if needed?

Learning Goal 2

Can an app promote mental health wellness and reduce feelings of isolation?

Learning Goal 3

Can an app promote wellness and recovery for individuals living with mental health challenges?

RDA has assessed the goals defined above to help San Mateo County BHRS understand the implementation of the apps and the outcomes of their utilization in the local context. The University of California Irvine (UCI) is also conducting a statewide evaluation of the County Behavioral Health Technology Collaborative to explore app usage trends, linkages to care, and recovery outcomes across all jurisdictions participating in the Help@Hand project.

As the project progressed, the Learning Goals were adapted to reflect emerging community needs, implementation learnings and evaluation goals.

Evaluation Timeline and Adaptations

The evaluation evolved as the Help@Hand Advisory Committee, BHRS and RDA identified lessons learned and carried those lessons forward by adapting the Learning Goals. This iterative process has allowed the evaluation to follow the evolution of the project.

Initially, the Learning Goals were stated as follows:

1. Does the availability and implementation of technology-based mental health apps connect transition age youth in crisis and older adults experiencing isolation to in-person services?
2. Does engaging with the apps promote access to mental health services and supports?
3. Does engaging with the apps promote wellness and recovery?

The first Learning Goal was originally intended to assess whether the availability and implementation of technology-based mental health apps connect **TAY in crisis** and **older adults experiencing isolation** to **in-person** services. Early stakeholder input prioritized TAY in crisis and isolated older adults. Early stakeholder input prioritized the importance of in-person support and raised concerns about the idea of a technology-based solution replacing in-person connections.

Early conversations with our local youth crisis response center staff and stakeholders led to an agreement that youth in crisis are best served by live, trained peers with clinical supervision (rather than through a digital tool such as the app, which uses AI). Additionally, the available technologies, which

were approved through a Request for Statement of Qualifications (RFSQ) process led by CalMHSA, were not equipped to address youth in crisis. This led to the first change in our Learning Goals to focus on supporting the mental wellness of TAY in general and alternatively investing in the expansion of the local crisis hotline resources to include text-based and social media supports in preparation for the app release. The selected app would be customized to include local crisis resources and a means to connect users that may need additional supports to live crisis center resources via voice call, chat and/or text.

Furthermore, given the restriction on in-person activities after the onset of the COVID-19 pandemic, in-person services were not a feasible resource. Therefore, the first Learning Goal was modified accordingly to assess whether a mental health app can connect both older adults and TAY in general (vs. those in crisis in particular) to mental health and other supports (not just in-person) if needed.

During the pandemic, a greater concern arose regarding feelings of isolation among both the older adult and TAY populations. Therefore, the second Learning Goal was modified to assess whether an app can promote mental health wellness and reduce feelings of isolation

The third Learning Goal further specified that this was for individuals living with mental health challenges. Early in the implementation of Help@Hand, staff and stakeholders determined that it would be much more feasible to work through the app vetting, selection, piloting, and customization processes working with older adults and TAY in the community (vs. in clinical care with BHRS clients). After Wysa was selected as the app to support wellness, reduce isolation, and promote connections to supports, BHRS testing with clients focused on determining whether this app in particular met the project's goals for individuals living with mental health challenges and specifically whether it promotes their wellness and recovery.

The final Learning Goals were adapted as follows:

1. Can a mental health app connect transition age youth and older adults to mental health services and other supports if needed?
2. Can an app promote mental health wellness and reduce feelings of isolation?
3. Can an app promote wellness and recovery for individuals living with mental health challenges?

Data collection for this evaluation report focused on the implementation of the following activities undertaken by BHRS and local stakeholders throughout the three year evaluation period: (a) activities related to app vetting, testing, and selection, (b) a two-month pilot process with older adults and TAY (c) app exploration groups to identify customization needs, (d) further testing with behavioral health consumers and (e) broad deployment of the app to the target communities including data collected and findings from this deployment to County residents.

Evaluation Methods

Data Collection

RDA used both quantitative and qualitative evaluation methods to assess the influence of the Wysa app on pilot participants' well-being, feelings of isolation, mental health stigma, and potential connections to further mental health supports if needed. Qualitative app exploration was also conducted in early pilot phases to identify considerations for app customizations, further testing with San Mateo County behavioral health consumers, and broad deployment to the target populations.

Additionally, qualitative and quantitative data were collected from the perspectives of different stakeholders involved in implementation and decision-making processes, including the Help@Hand

Advisory Committee and peer partner agencies. RDA collected data through interviews, surveys, and four focus groups with the following stakeholders:

Table 2. Data Collection Activities and Participants

Method	Stakeholders
Interviews	Doris Estremera, MHSA Manager[3]
	Rubi Salazar, Peer Program Coordinator, Youth Leadership Institute (YLI)
	Ahleli Cuenca, Bay Area Director of Programs, YLI
	Susan Houston, Vice President of Older Adult Services, Peninsula Family Service (PFS)
	Patricia Duarte, Peer Support Specialist, PFS
	Cristian Huezo, Peer Support Worker, PFS
Process Focus Group For Year 2 Reporting	Help@Hand Advisory Committee
App Vetting and Selection Focus Groups	TAY app testers (5)
	Older adult app testers (7)
Pilot Participant Focus Groups	TAY app pilot participants (16)
	Older adult pilot participants (37)
Pilot 1 Participant Survey	TAY app pilot participants
	Older adult pilot participants
App Exploration Groups	TAY participants (8)
	Older Adult participants (12)
Testing Participant Survey	BHRS Adult Clients
Testing Participant Focus Groups	BHRS Adult Clients
App Deployment Survey	San Mateo General Population (app users)

Interviews with Help@Hand staff and contractors explored key activities, lessons learned about the app pilot process and stakeholder engagement, participation in the statewide collaborative, and the potential impacts of behavioral health technology on the TAY and older adult populations. The focus group with the Help@Hand Advisory Committee offered an opportunity to discuss the role of the committee, successes and areas for improvement in the Help@Hand project activities, experiences working with different stakeholders, and changes in expectations of how technology can help meet the behavioral health and wellness needs of TAY and older adults in the county. RDA also attended monthly Help@Hand Advisory Committee meetings and documented the project's progress throughout the evaluation period.

RDA's role adapted as the needs of the project changed over time. When BHRS recognized the county would need to undergo an in-depth app pilot process, RDA worked with YLI and PFS to design and implement four focus groups with pilot participants. RDA, with the support of PFS, conducted one focus group with older adults, and YLI conducted a series of focus groups with TAY. Pilot participant focus groups were used to collect feedback on usage experiences with the Wysa app and the perceptions of each app's ability to meet the local Help@Hand Learning Goals and needs of the TAY and older adult populations. RDA also conducted two exploration groups, one with TAY and one with older adults to further explore specific app features of interest and inform the customization and app deployment phases of the Help@Hand project.

[3] As the MHSA Manager and the Help@Hand project manager, Doris Estremera oversees all project activities.

San Mateo County defines participants of the Help@Hand project as pilot users of the Wysa app—individuals who participated in the pilot stage by downloading and using the Wysa app. Accordingly, demographic data were collected in the form of surveys that were completed by both TAY and older adult participants prior to downloading and using the selected apps for a total of two weeks.

Individuals who participated in the pilot stage also completed surveys about their experiences with the app; they were assessed both before and after the pilot period to determine whether engaging with the app was related to any increase in particular favorable outcomes, and/or whether unfavorable outcomes or risk factors decreased after engaging with the app. In the Final phase of the project, County residents who downloaded the app were also invited to complete a brief feedback survey. Participants were contacted by email and invited to complete the survey; 30 participants responded.

Data Analysis

To analyze the qualitative data, RDA transcribed interview and focus group participants' responses to capture their sentiments and perceptions. RDA then thematically assessed responses from all participants and identified recurring themes and key findings.

To analyze the quantitative data, RDA tabulated frequencies and percentages of app testers' demographic information (i.e., age group, assigned sex at birth, gender identity, race/ethnicity, sexual orientation, employment status, etc.) as well as app testers' responses to survey questions developed to elicit feedback about the overall usefulness of the app's functionality, feelings of isolation and connectedness, and perceptions about mental health.

Evaluation Limitations

Qualitative data collection and analysis was limited in scope by low numbers of participants available and willing to participate in focus group and interview activities. A larger study could have resulted in more nuanced findings. The evaluation was also impacted by changes in mental health needs and service availability related to the COVID-19 pandemic. The need to shift focus and adapt Learning Goals resulted in less ability to track attitudes and beliefs consistently across time.

Evaluation Findings

Wysa Pilot & General Population User Learnings

Aside from informing app customizations and the Wysa deployment plan, another objective of the Wysa pilots (with TAY, Older Adults, and BHRS clients) was to contribute to learnings related to the local Learning Goals.

The following sections provide an overview of how the pilot process and the general population survey contributed to each of San Mateo County BHRS Help@Hand Learning Goals.

For each data collection phase, demographic data can be found in Appendix A.

Learning Goal 1: Can an app connect transition age youth and older adults to mental health services and other supports if needed?

Data from the TAY and Older Adult pilots suggest that there is some potential for the Wysa app to help users feel more comfortable seeking mental health services and supports.

- **In the TAY pilot, 47% (n=15) agreed that they are more likely to reach out for help with their mental health and wellness after using Wysa. In the Older Adult pilot, 31% agreed (n=32).**

Survey results suggest that using the app did not significantly reduce measures of help-seeking stigma, but there were slight differences that represent potential for some individuals to reach out for support who may not have otherwise. Results for TAY in particular show some reduction in stigma.

- In the TAY pilot group, **67% agreed (n=15) in the post survey that they "know when to ask for help" compared to 44% (n=16) in the pre survey.**
- In the Older Adult pilot, this figure stayed relatively consistent: **89% (n=37) agreed in the pre survey that they "know when to ask for help", and 85% (n=34) agreed in the post survey.**
- In the TAY pilot, **60% agreed (n=15) that their "self-confidence would NOT be threatened if [they] sought professional help" compared to 56% in pre survey.**
- In the Older Adult pilot, **76% agreed (n=33) in the post survey that "[their] self-confidence would NOT be threatened if [they] sought professional help" compared to 83% in the pre survey.**

While using Wysa may encourage individuals to seek out additional resources and support, integration of these supports with the app and the ability to track whether users follow through with seeking support is limited. That is, while the app could feasibly help to reduce stigma and promote help-seeking, it does not always connect users directly with services. One feature that the app does have to connect users to services is the "SOS" feature, which users can use to reach out and seek out additional resources if needed. Selecting the "SOS" button brings users to crisis supports such as the Crisis Hotline and Text line.

- **In the TAY pilot, 33% (n=15) found the SOS feature of the Wysa app to be useful (28% moderately useful and 7% extremely useful). In the Older Adult pilot, 9% found the SOS feature useful (6% moderately useful and 3% very useful).**

In the pilot stage, almost two-thirds of the TAY and older adult participants did not use the SOS feature over concerns that this feature would contact emergency services immediately. As a recommendation to address this finding, BHRS worked with the Wysa app developers to include a local resource page accessible within the app to facilitate connections to mental health supports for those who may need it. The page includes a collection of local mental health resources for participants to review, should they be interested in exploring services beyond the app itself. The app developers also created an "Extra Resources" button alongside the "SOS" feature and created pathways for the chatbot to recommend the resource page to users.

Some pilot users did express that they would have liked to be connected to a person for more traditional counseling.

- One TAY user shared that it *"Would have been nice to have an option to talk to a human as opposed to just the bot"*

In the final survey with general population app users, **36% of respondents agreed with the statement, "Because I used Wysa, I am more likely to reach out for help with my mental wellness."** This is slightly lower than the percentage of pilot users who agreed with the same statement, but the general population survey respondents also reported substantially lower interaction with the app. Even with the lower exposure to all of Wysa's features, this represents a meaningful improvement in likelihood to seek support. The final survey also provides insight for the need for future BHRS services in terms of reducing stigma around mental wellness. For these survey respondents, 57% agreed with the statement, "I feel comfortable discussing topics related to mental health and mental illness," and 52% agreed with the statement, "I feel comfortable seeking mental health services (such as counseling/therapy)". While the survey returned a small number of responses and does not necessarily represent county residents, this data suggests that there is further room for efforts to reduce mental health stigma in the community.

Summary

Given the results from the survey that was completed by the pilot participants, there is some evidence to suggest that TAY users would be more willing to seek help for their mental health and wellness because of using the Wysa app, and that seeking help would not negatively impact their confidence and self-esteem. Among Older Adults, there is evidence that this population feels comfortable seeking support and understands when they need to reach out for help. Given that using the app itself did not seem to decrease their feelings of being left out after its use, it is important that the app offer connection to other avenues of support.

Learning Goal 2: Can the Wysa app promote mental wellness and reduce feelings of isolation?

Wellbeing

Based on findings gathered from focus groups and survey responses from two pilot groups and one test group (TAY, Older Adults, and BHRS Clients), results suggest that apps such as Wysa promote mental wellness for participants. In particular, participants from each of these groups reported the following common benefits of using Wysa:

- Enhanced self-care strategies
- Improved coping with feelings like anxiety, anger, sadness, and stress
- Better, more restful sleep

As one TAY pilot participant reported, "*I suffer from loneliness, and it was comforting that I could check in with the app anytime*". An Older Adult BHRS client likewise commented, "*I've been going through a health crisis, depression, inconveniences – it's helpful to have this tool. It helps with self-reflection, gives you an opportunity to pause and think through things*".

According to survey results, users in each of these groups experienced improvements in subjective well-being indicators after using Wysa for two months.

Figure 2-4 below depict pilot users survey responses to how they felt the app impacted their well-being, as represented by increased feelings of satisfaction, hope, and balance, and reduced feelings of nervousness, depression, and stress.

Figure 2. Survey Responses from TAY Respondents about Well-being (n = 16)

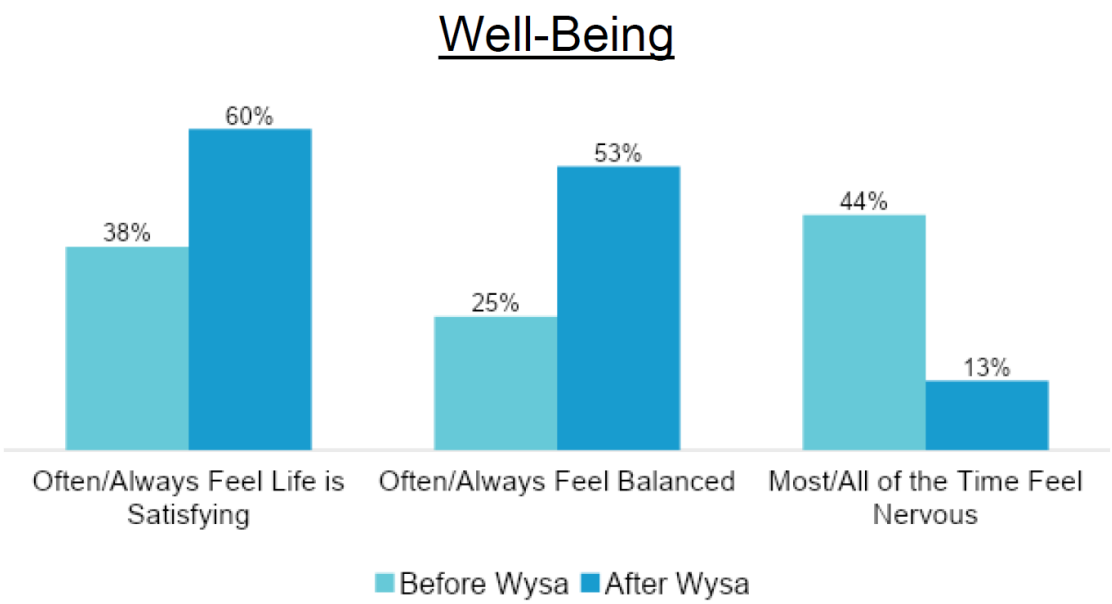


Figure 3. Survey Responses from Older Adult Respondents about Well-being (n = 37)

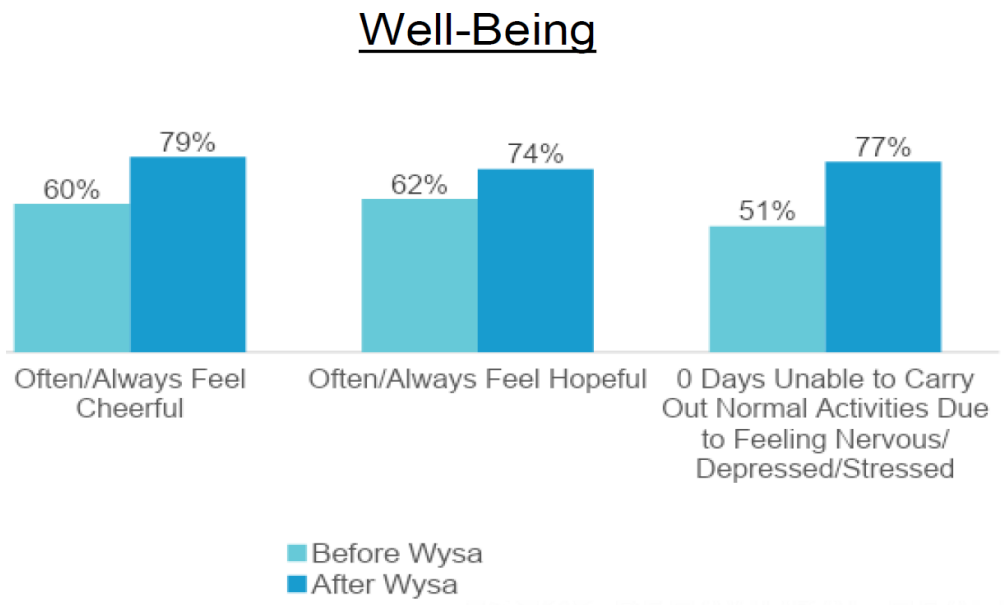
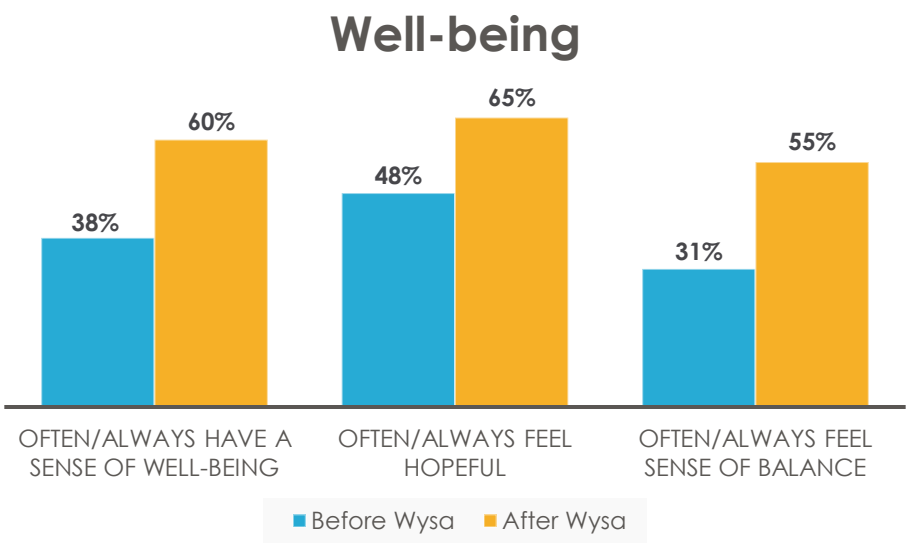
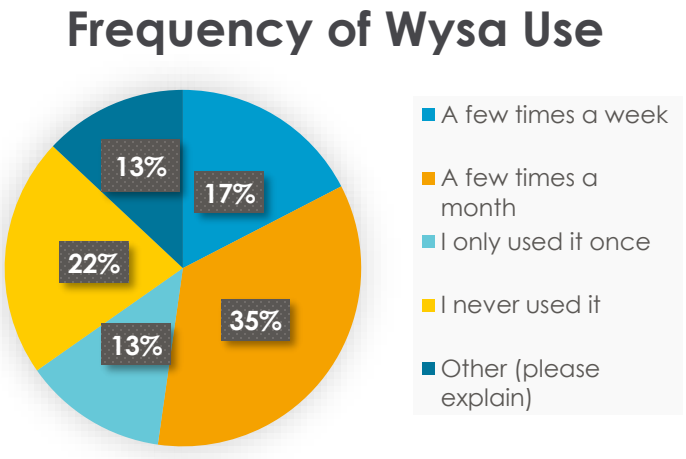


Figure 4. Survey Responses from BHRS client Respondents about Well-being (n = 20)



Notably, in the final survey of general users following the launch of Wysa to all County residents, results do not suggest the same level of potential for improving mental wellness as was seen in the pilot and test populations. Of those who completed a survey after downloading the app in this phase (21 users), **36% agreed with the statement, "Wysa improves my mental wellness," and 41% agreed with the statement, "Using Wysa makes me feel like I have more support when I am feeling down, stressed, or anxious."** It is important to note that this group overall had significantly less experience with the Wysa app than did the users in the pilot and test groups. As shown in Figure 6, 35% of the general population users who completed the survey either only used the app once or never used it at all. It is possible that these users did not experience as much benefit from the app simply because they did not actually make use of it, or made very little use of it, before reporting their feedback.

Figure 6. Survey Responses from General (SM County) Population (n=22)



Connectedness

Findings from the focus group and survey data demonstrate mixed impacts of using an app like Wysa on feelings of isolation and social connectedness. For the first TAY pilot, one of the first positive outcomes that staff noticed after the testing and piloting process was that the level of social connectedness

increased after TAY participants' use of the app. Other benefits reported by the older adult program staff included Wysa's chatbot feature, which provides suggestions to the user and prompts them to carry out a specific activity (e.g., positive affirmations, carrying out a physical activity) in response to a specific issue that the participant reports that they are currently experiencing within the app. Program staff also noted that youth reported that the Wysa app allowed youth a safe space to express any current issues or challenges that they were facing that day. Further, based on TAY participant feedback, program staff also noted that the Wysa app's chatbot features proved to be a valuable asset that TAY participants found helpful, especially after the onset of the pandemic.

Figure 6. Survey Responses from TAY Respondents about Connectedness (n = 16)

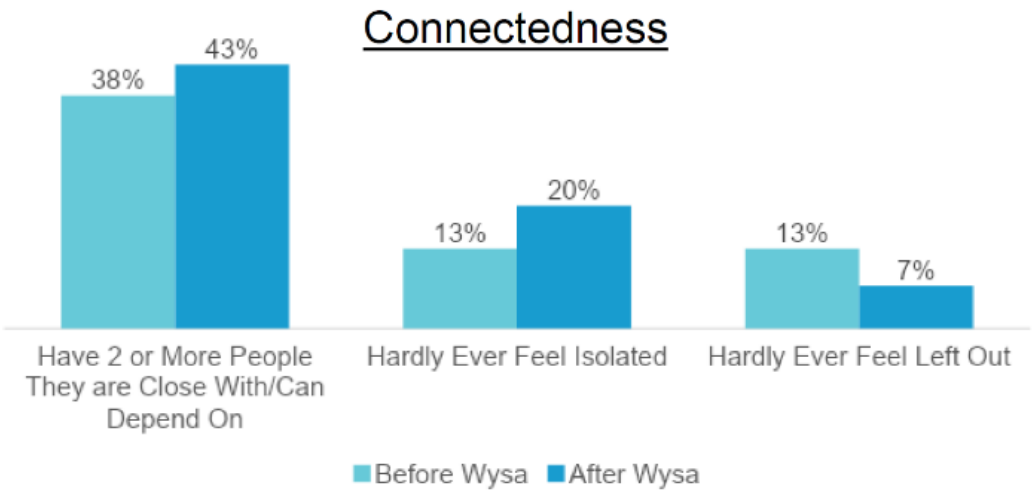
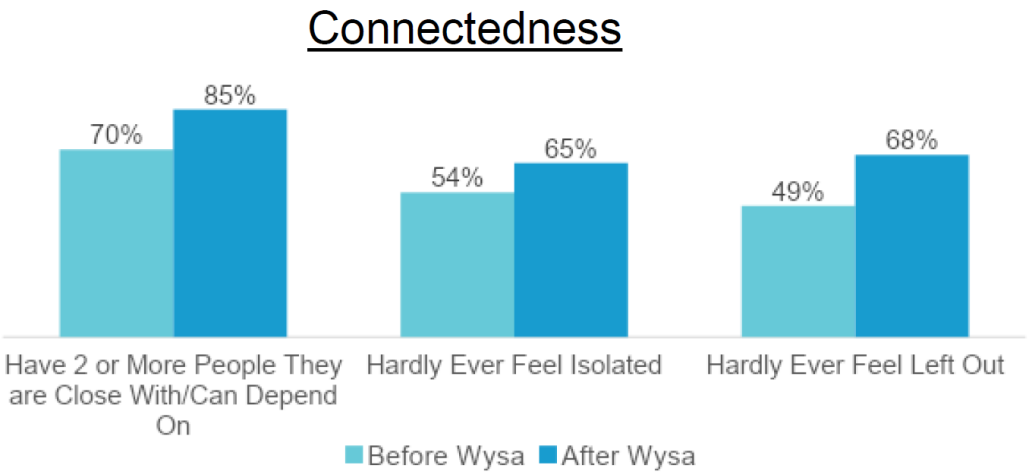


Figure 7. Survey Responses from Older Adult Respondents about Connectedness (n = 37)



For both TAY and older adults, after using the app, a greater number reported they have two or more people they are close with and can depend on, hardly ever feel isolated, and hardly ever feel left out.

While these results are promising, other survey question responses suggest that pilot users did not experience fewer feelings of isolation following use of the app but rather feel more connected to

support when they needed it. In surveys of early pilot users, **most (80% of TAY, 71% of Older Adults) did not agree with the statement "Using Wysa makes me feel connected to other people".** In the follow up pilot with BHRS clients, **most participants (79%) did agree with the statement, "Using Wysa makes me feel connected *to supports*,". Most users in all three groups (93% of TAY, 56% of Older Adults, and 79% of BHRS clients) agreed that "Using Wysa makes me feel like I have more support when I am feeling down, stressed, or anxious".**

The Wysa app's secure and private chat functionality were noted to enhance greater participation among TAY who may not otherwise engage in an in-person setting due to factors such as social anxiety or fear of being judged by peers. In Wysa, users can chat with an AI robot (i.e., chatbot), which then responds and recommends several self-care practices, such as mindfulness or physical movement activities or other resources in response to the user's issues or challenges mentioned in the chat. These chat functionalities were noted to reduce feelings of isolation and enhance social connection. Program staff also noted that the TAY testing participants seemed to value having access to chat-like features when using apps such as Wysa. **In fact, 80% of TAY and 53% of older adult users found the chatbot to be extremely or moderately useful.** Older adult users generally found the chatbot feature to be useful and enjoyed having a place to talk and share their feelings at any time of the day. They appreciated that the chatbot summarized what they said and referenced previous discussions. At the same time, some users noted that the chatbot's responses felt generic, unhelpful, and redundant, particularly when they used more complex language. Some also found it challenging to type everything they were feeling.

Similarly to the findings on mental wellbeing, the findings on isolation and connectedness are more limited in the general population. Among the group of users who responded to the survey, **41% either somewhat or strongly agreed with the statement, "Using Wysa makes me feel like I have more support when I am feeling down, stressed, or anxious."** This is substantially lower than the percentage of pilot and test users who agreed with the same statement. However, those groups reported more usage of the app and also received additional outreach and support for using the app that the general population did not receive.

Summary

Given the above findings from both surveys and focus groups, it seems that Wysa is generally beneficial in terms of both wellbeing and isolation, but that it does not eliminate the need for other behavioral health services and supports. In terms of wellbeing, the app promotes positive self-care and coping strategies. In terms of isolation, the app offers an outlet for folks to feel supported in times of need. However, using Wysa does not appear to eliminate distressing feelings and does not help people to feel more connected to others more broadly speaking. It is therefore important to consider Wysa as a supplementary resource that might be integrated with other supports to meet varying mental health needs for County residents. Additionally, given the differences in response between the pilot and testing groups and the general population, it seems likely that Wysa is significantly more effective as a tool for improving mental wellness and reducing feelings of isolation when it is provided along with other supports and resources.

Learning Goal 3: Can an app promote wellness and recovery for individuals living with mental health challenges?

Testing with existing BHRS clients demonstrated the ways that use of the Wysa app can integrate with and enhance other types of mental wellness support and resources to be a valuable tool in recovery for individuals with mental health challenges.

In surveys with BHRS test users, **79% agreed that using Wysa makes them feel like they have more support when they are feeling down, stressed or anxious. 75% agreed that using Wysa makes them feel connected to supports.**

For many of the test users, Wysa was a valuable supplementary resource, which they could turn to in addition to therapy or other resources they are already connected to. Using the app bolstered clients' self-care and coping strategies, eased loneliness, and allowed clients to feel even more connected and supported than with therapy alone.

- One Older Adult user shared that *"the app reinforces what I'm doing in therapy and expands it… The app will direct you to therapy or counseling and if you don't respond, the app will check in on you."*
- One TAY test user shared: *"I suffer from loneliness, and it was comforting that I could check in with the app anytime"*

Test users especially appreciated that the app is available 24/7, unlike traditional therapy or groups which tend to meet once or twice a week. Additionally, some users found it refreshing to use the app's tools and chat with the bot as a way to process thoughts and feelings without needing to share with another person. Some tools in the app were perceived as being more concrete than counseling, allowing users to work through issues in tangible ways and see their progress.

BHRS clients testing the Wysa app reported that the tools helped them manage feelings of anxiety, anger, stress, and loneliness, and helped them sleep better.

- One Older Adult client shared: *"I've been going through a health crisis, depression, inconveniences – it's helpful to have this tool. It helps with self-reflection, gives you an opportunity to pause and think through things"*
- A TAY client shared: *"[The app] helps me calm down. I used the talking feature and the self-care feature. Help with my anger and get a better night's rest."*

Summary

Results from surveys, interviews, and focus groups with BHRS clients who tested using the Wysa app show that the tools can support recovery when used as a supplement to traditional services. It will be critical to consider how clinicians can integrate the Wysa app into their practice with BHRS clients, allowing clients to benefit from a variety of tools and supports. The app offers some unique components that are not available with one-on-one or small group counseling (such as 24/7 access and integrated tracking tools) that may bolster these efforts and improve recovery for some clients.

Additional Findings

App accessibility and usability

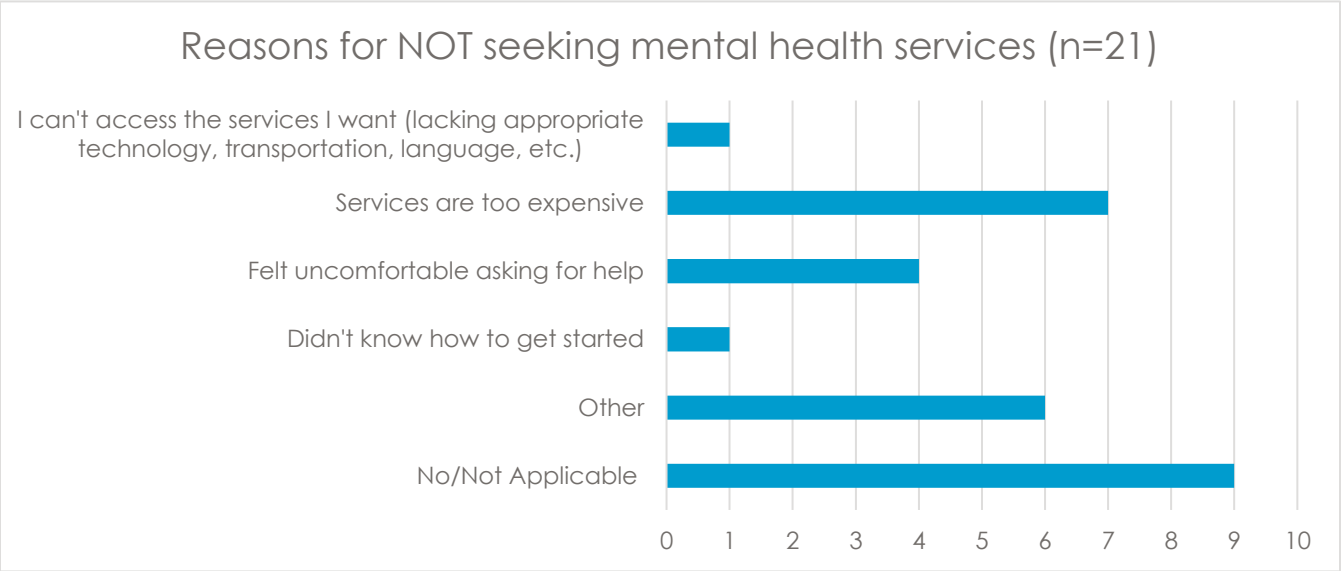
Based on survey responses and feedback from both pilot testing and the app launch, the Wysa app appears to be easy and intuitive to use and navigate. All of the TAY and 88% of older adults in pilot testing agreed that the app's language was easy to understand. Further, 93% of TAY and 88% of older adults in pilot testing agreed that the app was easy to use, while 76% of general population users agreed. Lastly, 87% of TAY and 69% of older adult pilot users reported that they would recommend using the app to others, and 62% of general population app users agreed. The availability of the apps content in various languages continues to be a concern among stakeholders. Stakeholders noted that BHRS did not identify a minimum viable product language requirement,[4] and that they are concerned

[4] A minimum viable product is the most basic version of a product that will still satisfy users. In this case, the minimum viable language requirements are the languages that the apps must offer to meet the fundamental linguistic needs of the target populations.

about moving forward with an app that has limited, or no, features for monolingual Spanish or Chinese speakers given the strong presence of these communities in San Mateo County. BHRS had initially hoped to include monolingual Spanish and Chinese speakers as target populations; however, they realized early in the Help@Hand project that they did not have the capacity to have priority populations in addition to older adults and TAY. However, reaching these two subgroups of the older adult and TAY populations continues to be an expressed interest of a number of stakeholders involved in San Mateo County's Help@Hand project. To address concerns, the Wysa app developers are currently working on a Spanish version of the app for future testing and piloting.

Accessibility of mental health services

In the final project stage, users who downloaded Wysa were asked in a survey, "In the past 2 months, have you chosen not to seek professional mental health services for any of the following reasons? Please select all that apply." Users reported that they have *not* sought services due to such factors as expense, discomfort, and lack of knowledge or access. While Wysa may encourage users to seek out mental health services, it will be critical to ensure that these barriers are considered.



Conclusion

The key evaluation findings outlined in this report can provide guidance for future directions and decisions regarding the sustainability of the Wysa app as a tool to support mental wellness and connect individuals to mental health resources in a non-stigmatizing and relevant manner, especially as we launched into a digital world post COVID-19.

It will be important to continue to consider ways to connect users with in-person services and resources from the app and to ensure that the app's tools are accessible to those with varying needs. Specifically for TAY, it will be important to identify ongoing best practices to support their mental health and wellness and mitigate barriers and/or stigmas. For Older Adults, more research is needed to focus on the various stigmas experienced within this population and possible reasons as to why older age-range adults, those between the ages 75 to 90, might be reluctant to seek mental health and wellness resources, and whether using an app is even an appropriate tool culturally appropriate way to engage the older age-range adults in wellness and possible connections to additional mental health supports if needed.

This report also serves as an opportunity to highlight unanticipated successes as San Mateo County responded to client and community technology-related needs that evolved during the course of this

Innovation project and were exacerbated by the COVID-19 pandemic. The local Learning Goals of this project centered around identifying an app or technology-based solution for supporting the mental health needs of consumers. While San Mateo County did identify and implement a wellness app to support these goals, the county ended up addressing so much more in the realm of digital supports including:

- Digital Mental Health Literacy (DMHL) training for peer staff
- Get App-y Workshops for older adults to receive supports with basic 101 technology education
- Expansion of the local youth crisis hotline to include text-based and social media supports
- 700+ Device and data plans distribution to clients to support engagement in services
- Tech Cafés or workshops for clients and the community at large to receive basic technology supports and 101 technology education

The Help@Hand Advisory Committee was engaged in a conversation around sustainability of the above mentioned Help@Hand activities and the Wysa app deployment. Stakeholders were asked: 1) What activities are a priority to sustain? And 2) Are there any changes we would like to see to any of these activities? Text-based/social media crisis supports for youth, device/data plan distribution, Get App-y Workshops, and Wysa deployment were prioritized in that order.

Prior the end of the Innovation pilot period, San Mateo County was able to secure ongoing MHSA funding for the text-based/social media crisis supports for youth and device/data plan distributions to clients.

The Get App-y Workshops and Wysa deployment activities were funded for one-year with one-time MHSA funding to allow for continued evaluation of the need and impact. The Wysa deployment activities includes contracts with 1) Painted Brain, a peer-run, peer-led agency that will support behavioral health clients with digital and technology needs related to their devices and the Wysa app; 2) Peninsula Family Service (PFS) and Youth Leadership Institute (YLI) to continue outreach activities to promote the Wysa app among vulnerable older adults and TAY that may need more supports; and 3) marketing activities, focused on social media ads only, to promote Wysa amongst the general San Mateo County population of older adults and TAY.

To-date, PFS staff have found it challenging to promote the use of an app with vulnerable older adult populations. The older age-range adults are much more interested in the Get App-y Workshops than the app. Older adults find it difficult to download and use the app without staff support and those that do use, don't engage with it ongoing. Pending the success of Wysa uptake broadly across the general San Mateo County population, amongst BHRS clients, and PFS and YLI outreach activities, decisions will be made for the continuation of Wysa app deployment past June 2023.

Appendix A: Demographic data

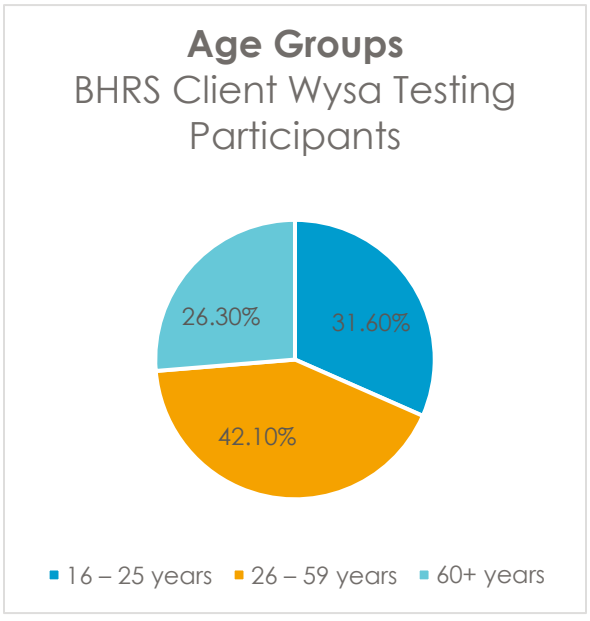
Pilot Focus Group, Interviews, and Survey respondents

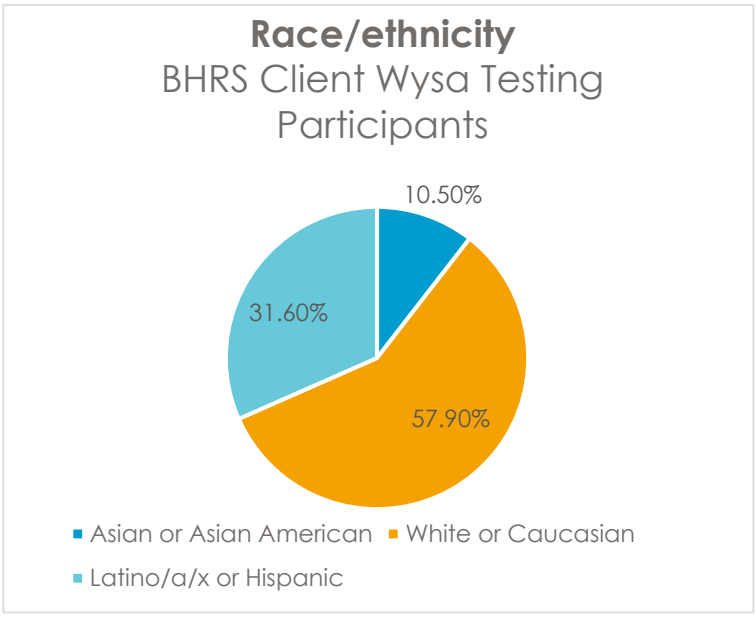
The demographic characteristics of pilot participants by target population are presented in the table below:

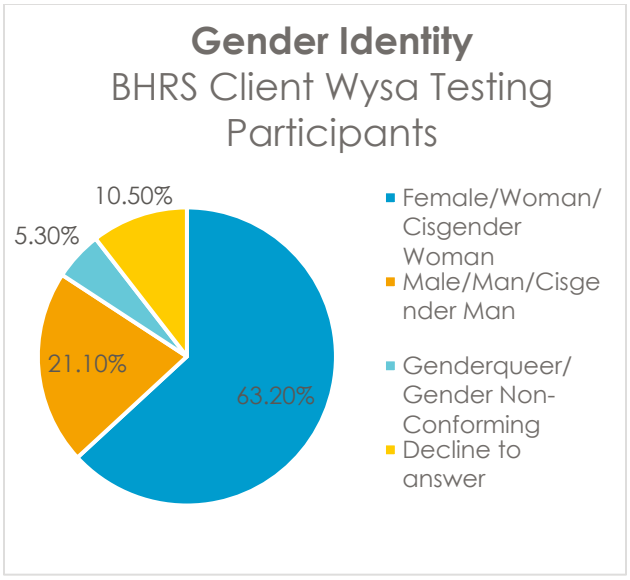
Older Adult and TAY Wysa Pilot Participant Demographics	
Older Adults	**TAY**
• Average 69 years old (range: 55 to 89 years) • 78% were female • Majority identified as White/Caucasian (83%) • 87% identified as straight/heterosexual • Most held a bachelor's or graduate degree (38%) • 52% reported no mental health challenges • 51% retired • 28% made under $30k per year	• Average 17 years old (range: 14 to 24 years) • 75% were female • Majority identified as Asian (50%), followed by Hispanic/Latino (38%) • 67% identified as straight/heterosexual • 81% were high school students • 43% reported no mental health challenges • 50% were students • Came from various households with a wide range of annual household incomes

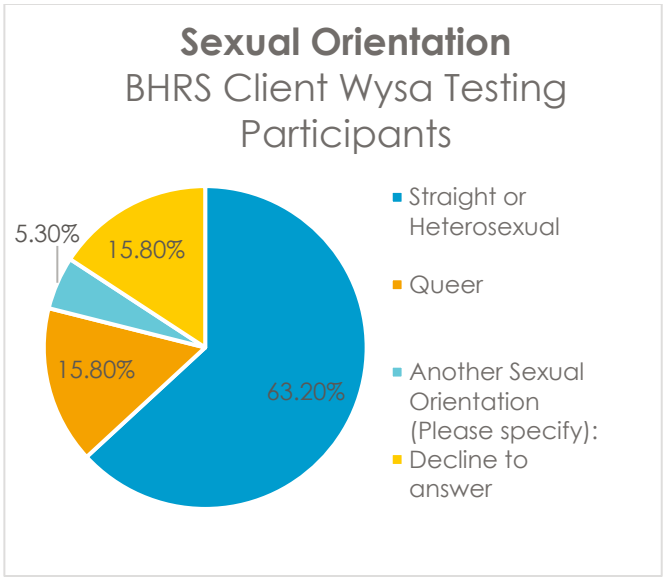
BHRS Client Focus Group, Interview, and Survey respondents

The demographic characteristics of participants in BHRS client app testing (n=19) are presented in the charts below:



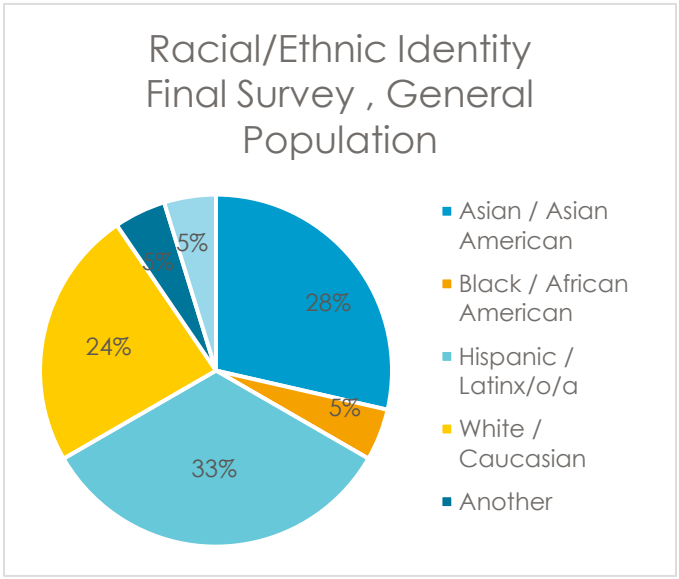


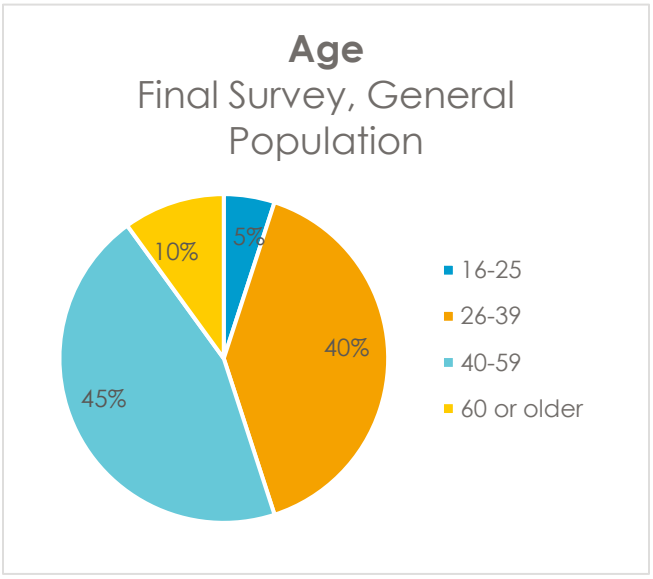


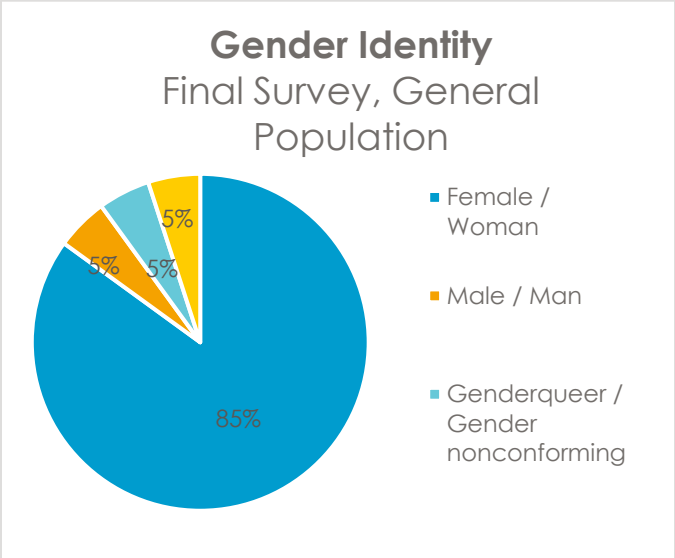


General Population Wysa user Survey respondents

The demographic characteristics of respondents to a follow up survey among general population county residents (n=21) are presented in the charts below:






Gender Identity
Final Survey, General Population
5%
5%
5%
85%
Female / Woman
Male / Man
Genderqueer / Gender nonconforming

SPOTLIGHT
San Mateo County's Wysa Pilot

wysa

San Mateo County Behavioral Health and Recovery Services and its contracted partners, Peninsula Family Services and Youth Leadership Institute, piloted the Wysa app with 37 older adults[1] and 16 transition age youth (TAY)[2] between April and July 2021. Pilot participants completed pre and demographic surveys, engaged with the app for two months, and then completed post surveys, focus groups, and app exploration sessions.

Data were collected and analyzed by Resource Development Associates (RDA) Consulting. This spotlight highlights excerpts from the pilot reports and presentations developed by RDA Consulting. The full pilot reports can be found in Appendix C.

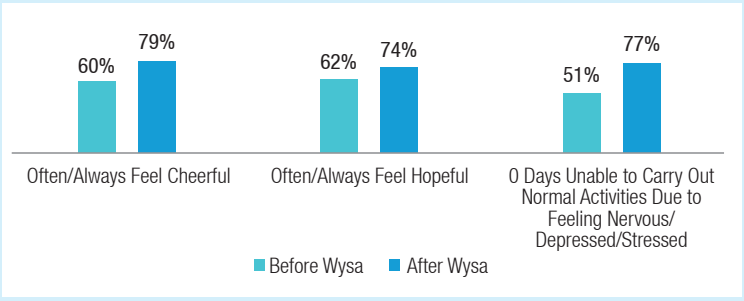
[1] 37 older adults completed the pre and demographic surveys, 34 completed the post survey, 30 participated in the focus groups, and 12 participated in the app exploration.
[2] 16 TAY completed the pre and demographic surveys, 15 completed the post survey, 13 participated in the focus group, and 8 participated in the app exploration.

PILOT LEARNING OBJECTIVE #1: Can an app promote mental health wellness and reduce feelings of isolation?

MENTAL HEALTH AND WELL-BEING

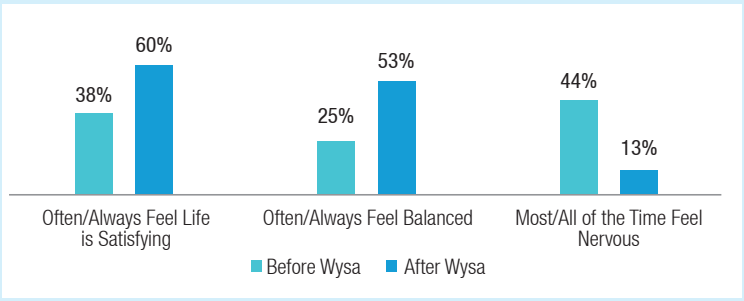
Older Adults

The proportion of favorable responses among almost all (18 out of 21) metrics related to mental health and well-being increased or stayed the same after using Wysa. This suggests that **using Wysa may have helped improve pilot users' mental health and wellbeing**. The largest increases were as follows:



TAY

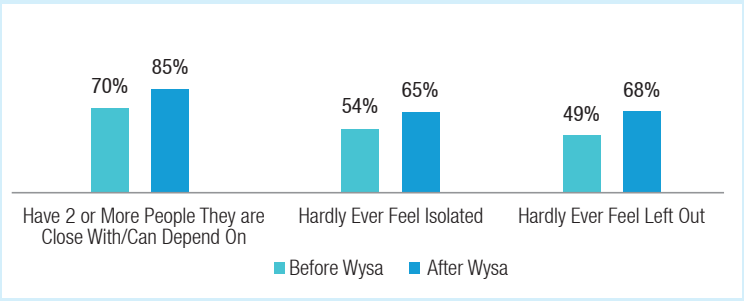
The proportion of favorable responses among almost all (19 out of 21) metrics related to mental health and well-being increased or stayed the same after using Wysa. This suggests that **using Wysa may have helped improve pilot users' mental health and wellbeing**. The largest increases were as follows:



PERSONAL CONNECTIONS

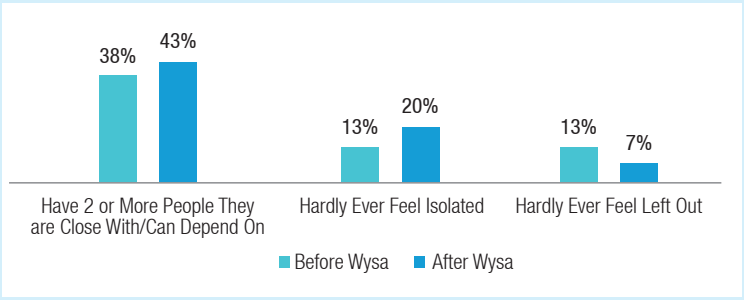
Older Adults

The proportion of favorable responses among all 4 metrics related to personal connections/isolation increased after using Wysa. This suggests that **using Wysa may have helped improve pilot users' feelings of isolation and connectedness**. The largest increases were as follows:



TAY

The proportion of favorable responses among almost all 4 metrics related to personal connections both increased and decreased after using Wysa. This suggests that **using Wysa may have had different impacts on users' feelings of connectedness**. Key findings were as follows:



PILOT LEARNING OBJECTIVE #2: Can an app connect transition age youth and older adults to mental health services and other supports if needed?

SOS Button

The SOS Button allows users to develop a safety plan and directs users in crisis to international crisis helplines.

% of users who...	Older Adults	TAY
did not use the SOS button	69%	60%
found it very, extremely, or moderately useful	9%	34%
found it slightly or not at all useful	22%	7%

Most older adult and TAY users were "afraid" or "scared" to use this feature as they thought emergency services would be contacted.

A few older adult users did not notice the feature at all.

EXPERIENCES WITH WYSA: STRENGTHS AND CHALLENGES

Older adults and TAY identified a number of strengths and challenges. The percentages represent the respondents who agreed or mostly agreed with each statement.

STRENGTHS

	Older Adults	TAY
Usage & Accessibility		
The language is easy to understand	88%	100%
Wysa is easy to use	78%	93%
Wysa is visually appealing	75%	87%
Would recommend Wysa to others	69%	87%
Support for Mental Health & Wellness Needs		
Wysa improved my mental health and wellness	56%	67%
Wysa makes me feel like I have support when feeling down, stressed, or anxious	56%	93%
I find Wysa useful in my daily life	53%	60%
Culture		
Wysa values and respects cultural differences*	31%	60%

CHALLENGES

	Older Adults	TAY
Support for Mental Health & Wellness Needs		
Because I used Wysa I am more likely to reach out for help with my mental health and wellness	31%	47%
Wysa makes me feel connected to other people	29%	20%
Wysa has helped me detect symptoms related to my mental health and wellness	22%	47%
Culture		
Wysa values and respects cultural differences*	31%	60%
Wysa demonstrates knowledge about my culture	13%	33%

*Older adults found this to be a challenge, while TAY found it to be a strength.

OVERARCHING USER RECOMMENDATIONS[3]

The following recommendations were shared by users in the post survey, focus groups, and app explorations.

Technical Support

- Create instructions, tutorials, and/or workshops focused on downloading and using the Wysa app.

Accessibility

- Enable Wysa to function offline to provide access to users with limited internet connection.
- Optimize Wysa for all devices and offer tutorials on how to configure app settings on different devices.
- Ensure the language, locations of the buttons, and content are optimized for users with cognitive or physical impairments.

User Engagement and Notifications

- Make the notifications and reminders more engaging for TAY users.
- Explore gamification strategies to incentivize users to engage with the app more frequently.
- Remind users of the ability to customize notifications.

Disclaimers and Notifications

- Add a disclaimer about the app's intended purpose, including that the app is a light touch resource for mild mental health and wellness concerns and is not a replacement for therapy.
- Offer users more control over app notifications, including frequency and how they are received (e.g., phone, email).

Content

- Include an in-app directory/search function.
- Ensure Wysa is inclusive of and responsive to individuals of different cultures and communities (e.g., LGBTQ+, different races/ethnicities) by reviewing and revising the content throughout the app as needed.
- Remove mentions of any other features that require a fee.
- Offer additional in-app customizations (e.g., colors, backgrounds/wallpaper, layout).

[3] User recommendations were condensed for the purpose of this spotlight. Complete lists for older adults and TAY are available in the pilot reports developed by RDA.

Campaign Report

2022 Wellness For All Campaign

San Mateo County Behavioral Health and Recovery Services (BHRS)

Uptown Studios
DESIGNS FOR SOCIAL CHANGE

Campaign Goals + Objectives

Uptown Studios partnered with San Mateo County Behavioral Health and Recovery Services (BHRS) to manage its 2022 Wellness For All campaign. There were two target audiences for the campaign: Older adults aged 55+ and younger adults aged 14-29.

The campaign's goals were to obtain 7,000 downloads and sign-ups of the Wysa app by the end of 2022 while working to reduce the stigma of mental health support, normalize asking for help, and drive awareness of the services and resources available to older adults aged 55 and over.

Table 1 below provides the terms and definitions related to digital measurements and what is defined as a "good" outcome. These terms are referenced throughout this document. Table 2 below outlines all of the campaign strategies and each outcome.

Table 1

Measurement & Definition	Defined as "good"
Engagements - The number of likes, comments and shares.	1% - 5% of your followers
Impressions -The number of times your content is displayed, no matter if it was clicked or not.	The higher the better. There is no "ideal" reach-to-impression ratio, but anything less than 0.2 is not ideal.
Reach - The total number of people who see your content.	Instagram average: 13.51% of followers Facebook average: 8.6% of followers
Post Clicks - The number of times someone clicked on the ad.	2% of impressions
CTR (Click-through Rate) - the percentage of people visiting a web page who clicked on the link of an ad.	2% is considered good
Total Net Audience Growth - The number of audience members you acquired during the reporting period.	Instagram - 1.5% per week is good Facebook - 0.64% per week is good

Table 2

Strategy	Outcome
Digital Ads - Generate three social media and Google ads per audience to increase the number of app downloads from June 29, 2022, to September 22, 2022.	There were a total of six ad campaigns that ran on Facebook and Instagram from June 29, 2022, to September 22, 2022. Three of the ad campaigns targeted older adults, and three targeted younger adults. During that time, there were 20,079 ad clicks resulting in an average click-through rate of 0.51%. The top ad included candid imagery of a young adult on their phone. That ad recieved a total of 485 clicks. One Google Ads campaign targeting older adults ran from June 29, 2022, to September 22, 2022. This campaign received 1,771 clicks and had 42,163 impressions.
Organic Social Media - Create an organic social media plan for 2022 to increase awareness of the Wysa app and services offered by San Mateo County BHRS.	Uptown Studios created organic social media content to share on San Mateo County Health and its partner's social media pages. Organic social media content was only shared on San Mateo County Health's social media pages from June 28, 2022, to August 17, 2022. During that time, there were 15,628 engagements, 1,676,146 impressions, and 7,115 post clicks.
Billboards and Transit Shelter Ads - Utilize billboards and transit shelter ads to promote the app to potential users.	Uptown Studios created a single ad to display on 30 buses throughout San Mateo County. The ads were displayed on the outside of buses beginning August 22, 2022, and will stay through December 31, 2022. The ads are on 15 buses on the North garage route and 15 on the South garage route in San Mateo County.

Partner Toolkit - Create a digital partner toolkit to provide partners with the necessary tools to encourage community engagement.	Uptown Studios created a digital partner toolkit that included social media, flyers, eblast content, and texting information. San Mateo County BHRS distributed these toolkits to their partners, such as YLI and Peninsula Family Services.
Postcards - Use direct mail to send out two postcards with QR codes to allow users to download the app and sign-up easily.	Uptown Studios developed two postcards, one for each target audience. Uptown Studios mailed 10,000 postcards on July 22, 2022. • Mailed one postcard to 2,949 Young Adults aged 18 to 24 living in San Mateo County. • Mailed one postcard to 7,051 Older Adults aged 55+ living in San Mateo County.
Monthly Eblasts - Send out monthly eblasts, including information about the app's services and instructions on downloading the app with the specialized codes from June 29, 2022, through September 22, 2022.	Monthly eblasts did not get prioritized in the budget; therefore, Uptown Studios did not create and send out monthly eblasts. However, the digital partner toolkits included eblast content, and partner organizations were encouraged to send an eblast to their contacts.
Flyers - Create flyers to be distributed by partners to local health care centers, older adult communities, and libraries with information on how to download and sign-up for the Wysa app.	Uptown Studios created two flyers, one for each target audience, and included them in the digital partner toolkits.
News Outlets - Contact local news outlets to promote information about the Wysa app and San Mateo County services and resources for older adults aged 55+.	Uptown Studios created and managed the implementation of a print ad for the Daily Journal. This ad targeted older adults aged 55 +. The ad ran weekly for five weeks, from July 25, 2022, to August 22, 2022. Because of the print ad space purchased, the Daily

	Journal gave San Mateo County BHRS a free digital ad space on its website during the same period.
Landing Page - Develop a landing page with information about Wysa, mental wellness, and the county's available resources.	Uptown Studios created content for the campaign landing page while CalMHSA managed the development portion. The landing page went live on March 7, 2022. There have been 868 page views with a bounce rate of 85.48%.

Digital Ads + Organic Social Media

Uptown Studios executed a combination of organic social media and paid digital ads to reach the target audiences. Uptown Studios incorporated positive and supportive messaging to reduce the stigma of mental wellness support. The graphics used had a diverse range of younger and older adults.

Uptown Studios created and scheduled posts across Facebook and Instagram from June 28, 2022, through August 17, 2022. Due to other health-related concerns within San Mateo County, the focus on the county's social media pages shifted, and Uptown Studios could not continue posting to the county's social media pages after August 17. Because the county's social media channels were not used for the entire campaign duration, Uptown Studios believes this affected the overall reach of the campaign messaging and is likely one of the factors that led to lower utilization of Wysa.

Paid social media ads ran on Facebook and Instagram from June 29, 2022, to September 22, 2022. There were 20,079 ad clicks across all paid social ads, resulting in an average click-through rate of 0.51%. The top ad, which received 485 clicks, included candid imagery of a younger adult on their phone.

Top Organic Social Media Posts

San Mateo County Health
Wed 7/20/2022 11:05 am PDT

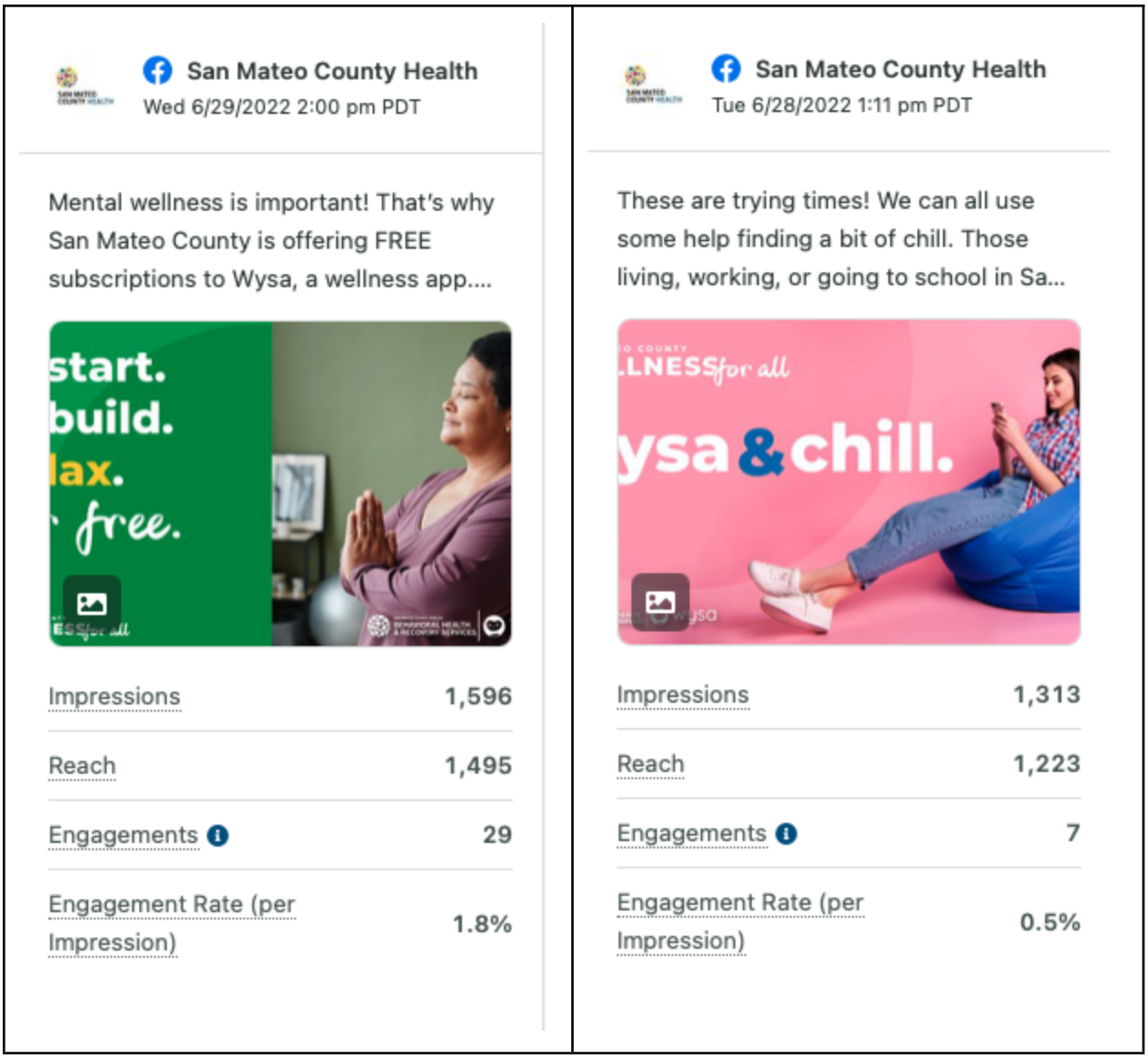
Find some peace and calm with FREE subscriptions to Wysa, available to everyone living, working, or attending...

Impressions	1,067
Reach	1,005
Engagements	11
Engagement Rate (per Impression)	1%

San Mateo County Health
Wed 7/6/2022 1:37 pm PDT

Open to trying something new? Work on self care, with Wysa, a wellness app for your phone or tablet, now available FRE...

Impressions	1,207
Reach	1,121
Engagements	11
Engagement Rate (per Impression)	0.9%



Organic Social Media Results

Measurement	Result
Engagements	15,628
Impressions	1,676,146
Post Clicks	7,115
Total Net Audience Growth	117

Top Performing Ad

Ad Image	
Headline	Reset. Rebuild. Relax. For Free
Description	Take a moment for yourself. Visit our website to access a FREE subscription to the mental wellness app, Wysa.
People Reached	219,658
Impressions	628,564
Clicks	485
CTR	0.08%

Paid Social Media Advertising Results

Measurement	Result
Reach	390,095
Impressions	3,931,261
Clicks	20,079
CTR	0.51%

Google Advertising Results

Measurement	Result
Impressions	42,163
Clicks	1,771
CTR	4.20%

Postcards

The Uptown Studios Team developed two postcards and mailed them to 10,000 San Mateo County residents. Each postcard was designed for a specific target audience: older adults and younger adults. By mailing postcards, San Mateo County BHRS could reach its target audiences directly in their homes. The postcards provided information about Wysa and led people to the campaign landing page to download the app and find other resources San Mateo County provides.

Target Audience	Graphics
Younger Adults – Mailed 2,949 of 10,000 postcards to Young Adults aged 18 to 24 living in San Mateo County	 PRIORITIZE YOUR MENTAL WELLNESS It's okay to need a little help sometimes. Your mental health is just as important as your physical health. San Mateo County Behavioral Health and Recovery Services has partnered with Help@Hand to offer a free subscription to the Wysa app to those living, working, or going to school in San Mateo County to get you the help you are looking for. It's Okay To Not Be Okay. To download the app, use this QR code, or visit this link: HelpAtHandCA.org/San-Mateo BEHAVIORAL HEALTH & RECOVERY SERVICES wysa

Older Adults –

Mailed 7,051 0f 10,000 postcards to Older Adults aged 55+ living in San Mateo County

Bus Ads

Uptown Studios created a single ad to display on 30 buses throughout San Mateo County. The ads were displayed on the outside of buses beginning August 22, 2022, and will stay through December 31, 2022. The ads are on 15 buses on the North garage route and 15 on the South garage route in San Mateo County. The bus ads will receive 7,800,000 impressions. This number estimates the number of people who will see this ad based on traffic in the area during the buses' run. Uptown Studios could not obtain transit shelter ads or billboards because of the high cost and lack of availability in San Mateo County.

Images of Bus Ad

Partner Toolkit

The Uptown Studios team developed a digital partner toolkit for San Mateo County BHRS to share with existing partners and local organizations in San Mateo County. The toolkit included a description of the Wellness For All campaign, two flyers, social media content, eblast content, and texting outreach content. San Mateo County BHRS sent these toolkits to YLI, Peninsula Family Services, and over 2,000 members on their subscriber list.

Link To The toolkit

https://drive.google.com/file/d/1BC8scJRLfdJqDrUlV5sfV3qYQMs385nt/view?usp=sharing

Print Ad

Uptown Studios created and managed the implementation of a print ad for the Daily Journal. A print ad was chosen to target older adults aged 55+ because it is a media outlet that this age group commonly uses to receive news and other information. The ad ran weekly for five weeks, from July 25, 2022, to August 22, 2022. Because of the print ad space purchased, the Daily Journal gave San Mateo County BHRS a free digital ad space on its website during the same period.

Images of Print + Digital Ads

Print Ad	Digital Ad
 IT'S OKAY TO NOT BE OKAY The hectic times we're living in have taken a toll on us all. We want you to know, it's okay to not be okay. San Mateo County has resources available to help! Get Free Access To The Wysa Wellness App And Other Resources Available In The County To download the app, use this QR code, or visit this link: HelpAtHandCA.org/San-Mateo BEHAVIORAL HEALTH & RECOVERY SERVICES | wysa	 Stay connected to the person that matters most, **YOU.** **Note:** This ad was clickable and drove people to the campaign landing page.

Landing Page

Uptown Studios created content for the campaign landing page while CalMHSA managed the development portion. The landing page went live on March 7, 2022. The landing page included information on downloading and signing up for the Wysa app, a video about Wysa, and a list of resources available to older adults in San Mateo County. There was also a survey that users were required to complete to get their access code and free access to the app for the first three months of the campaign.

For September, the landing page had 868 page views, and users spent an average of 2:42 minutes on the page. The landing page had a bounce rate of 85.48%, meaning that 85.48% of visitors left the page after clicking on the link. The highest pageviews were from September 12, 2022, to September 15, 2022.

Campaign Summary

To achieve the campaign goal of obtaining 7,000 Wysa app downloads by the end of the year, Uptown Studios implemented several strategies. Organic social media and digital ads were two strategies implemented to reach both target audiences. These strategies encouraged San Mateo County residents to download Wysa, provided resources available to older adults, and destigmatized talking about mental health.

To drive awareness of the campaign and encourage Wysa app downloads, Uptown Studios used bus ads, print ads, and postcards. Bus ads are displayed on 30 buses throughout San Mateo County until December 31, 2022. A print ad ran in the Daily Journal weekly for five weeks, from July 25, 2022, to August 22, 2022. Postcards were sent to 10,000 San Mateo County residents in June 2022. Both the bus and print ads targeted older adults in San Mateo County, while the postcards targeted older and younger adults.

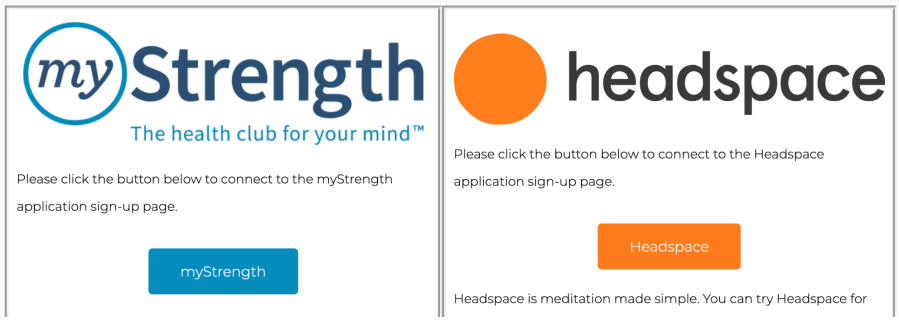
A Digital Partner Toolkit was sent out to over 2,000 partner organizations in San Mateo County. The toolkit included flyers, eblast content, organic social media content, and texting information. The toolkit's purpose was to have partners talk to their communities about the campaign, show their community members how to download Wysa, and share other resources available to older adults through San Mateo County.

All materials created for the campaign drove to a landing page for which Uptown Studios provided copy and graphics. It included information about Wysa and resources available through the county. People who downloaded the Wysa app had to go through the landing page to receive an access code.

There were 285 Wysa app downloads by September 2022. The number of Wysa app downloads, thus far, is less than anticipated. Uptown Studios provides recommendations in the section below to improve the number of downloads by December 2022.

Recommendations

- Simplify the landing page
    - Turn all links on the landing page into a button, so the links are more eye-catching
        - Examples:



- Promote Wysa app using messaging that highlights app features and use other well known sources that have written articles or made posts about Wysa to share on social media
    - “Having a hard time falling asleep at night? Wysa offers sleep stories to help you fall asleep and stay asleep! Get FREE access to the app through San Mateo County. Visit our website to get your free access now!
    - Example of articles to share: https://www.businesswire.com/news/home/20220718005028/en/Wysa-Secures-20m-to-Address-Global-Mental-Health-Demand-With-AI-Digital-Therapeutics

    - Have someone well-known from the county talk about why they love the app
        - Have a sports player, team mascot, mayor, etc take a video talking about Wysa and how the county is offering free access and post that to social media or the landing page.
- Resume organic social media postings. Halting posts half way through the campaign caused a setback on reach.
    - The algorithm (on all social media platforms) appreciates more frequent posting - around three to four times per week.
    - Consider creating new social media accounts under “Wellness For All” rather than using the county's social media accounts. This allows you to target the specific audience for this campaign by tailoring the posts and messaging for them
        - Uptown has created Berkeley Wellness For All and Tri-City Wellness For All social media accounts for similar campaigns
    - Continue encouraging partners to share and repost BHRS social media posts to increase reach and engagement

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Date: May 19, 2023

To: Help@Hand Collaborative Cities and Counties
From: CalMHSA
Re: CalMHSA Comments on Help@Hand Year 4 Evaluation Report

Dear Help@Hand Cities and Counties,

CalMHSA is proud to support this multi-year innovation project, in which 11 California Cities and Counties work together to explore mental health solutions through the use of technology. At publication of this report, Help@Hand project has achieved the following accomplishments:

- Over 25 product launches (pilot or general implementation) to date
- More than 45,500 licenses utilized for mental health technologies made available through Help@Hand
- 40+ vendor contracts managed
- Increased awareness of the importance of digital literacy for product adoption

A key component of this project is evaluation, which reports results on an incremental and annual basis. The following report comprises Year 4 (January -December 2022) of the Help@Hand evaluation and synthesizes evaluation findings across Cities/Counties.

The analysis and findings presented are those of the University of California, Irvine's (UCI) Help@Hand evaluation team. CalMHSA works collaboratively with UCI throughout the project and reviews the report for confidentiality, but neither CalMHSA, nor Cities/Counties are authors of the report.

How to Read This Report

Evaluation reports are written with the Help@Hand Cities/Counties in mind as the target audience, however the project understands there are many other stakeholders who also have interest in these reports. Evaluation reports are not intended to be exhaustive. They are intended to provide Cities and Counties with formative feedback that can be integrated during the project, rather than waiting until the project conclusion. Recommendations include both learnings and recommendations based on the experience of one or more Cities/Counties. Recommendations do not constitute failures, rather opportunities to share insights or ways to advance the work of others in the true spirit of innovation.

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Despite the details provided in the report, readers should note the analysis and findings outlined herein are still a summary and do not constitute all City/County, collaborative or project management activities completed during this evaluation period.

CalMHSA invites Help@Hand Cities/Counties to consider the following as they review the report:

- **Reflect** – Review and acknowledge the incredible work that has been done to date. Projects of this size take a large community to deliver, so please take the time to recognize those on your teams, and in your communities, who have worked diligently to bring the project this far.
- **Learn** – One of the primary intentions of innovation projects, including the Help@Hand project, is to learn. Learning includes both acknowledgement of successes that can be shared with other counties or stakeholders, and consideration of opportunities to improve. CalMHSA respects the openness and vulnerability of all project participants in courageously embracing a learning mindset through which we explore and discover innovative solutions and approaches to improve our communities and save lives.
- **Respond** – After reading the report, if you have questions or wish to provide comments, please email your feedback to CalMHSA at helpathand@calmhsa.org and to UCI at dsorkin@uci.edu.

This report is a lengthy document, 206 pages. To assist you in navigating, here is a preview of how the report is organized, including the page number where each section begins:

- Executive Summary (page 5)
- Summary of Activities (page 10)
- Recommendations (page 153)
- Spotlights (pages 33, 63, 68, 98, 122, 139)
- City/County Program Information (page 160)
- Report Chapters are structured in the following format:
  - Key points
  - Overview
  - Methods & Findings
  - Learnings

Year 5 Mid-Year Report Preview

Below are some of the activities underway, which will be reported further during the next report period.

- Results, findings and learnings across the Collaborative from ongoing product launches and completed implementations

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- Implementation managers are working with Cities/Counties to prepare for technology and Help@Hand project transition
- City/County updates on how project activities and milestones are contributing to desired learnings and overall project success
- Cities/Counties are continuing their outreach activities to stakeholders and technology users, bringing innovation to their communities
- Cities/Counties are taking steps toward decisions related to product or service sustainability beyond the lifespan of the Help@Hand Innovation project

Thank you for your interest in the learnings from Help@Hand. Questions or comments can be provided by contacting CalMHSA at helpathand@calmhsa.org and to UCI at dsorkin@uci.edu.

APPENDIX 11. KAPWA CAFE INN EVALUATION REPORT, FY 2021-22

KAPWA KULTURAL CENTER

Kapwa Kultural Center & Café Evaluation

Annual Report: 2021-2022

RDA CONSULTING

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Kapwa Kultural Center & Café Evaluation

Annual Report: 2021-2022

Presented By:

RDA Consulting

This report was developed by John Cervetto, MSW, Stephanie Duriez, MS, and Vanessa Garcia, MPH, of RDA Consulting under contract with County of San Mateo, Behavioral Health, and Recovery Services.

RDA Consulting, 2022

RDA CONSULTING

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Table of Contents

Program Overview

The Kapwa Kultural Center & Café (KKC) is a Mental Health Services Act (MHSA) Innovation project introducing a new and innovative approach, a social enterprise, to providing culturally responsive and accessible services to the youth in and around Daly City. The County of San Mateo Behavioral Health and Recovery Services (BHRS) and the Office of Diversity and Equity (ODE)'s Filipino Mental Health Initiative (FMHI) have collaborated with the Daly City Partnership (DCP), which provides fiscal oversight of MHSA funding to KKC as it is a department within the DCP. These entities, alongside KKC's leadership team and Building Restoring and Innovating our Dedication to Generational Enrichment (BRIDGE) Advisory Board, have created a strong partnership over the last year to facilitate the implementation of the KKC.

In the first year, the KKC staff have also made considerable progress to meeting the goal of the KKC: a social enterprise café and community hub open to all people, especially Filipino/a/x youth, which provides culturally attuned behavioral health and wellness services, as well as opportunities for youth development. Youth can receive behavioral health linkages and entrepreneurship mentorship through their involvement and employment at KKC, all while learning more about their culture and identity. Additionally, KKC uses a social enterprise café business model to generate profit through the sale of boba tea and food items, to support the financial sustainability of KKC operations and the youth-focused programming. In the following section a description of the status of the KKC and the barriers and successes that have been encountered in the first year are provided.

Overall, the KKC's mission aims to help youth and the general community feel holistically well. This aligns with the goal of the KKC, and the DCP, to establish a presence in Daly City that encourages Filipino/a/x youth to increase their engagement with community services that are meant to increase their overall Ginhawa; which roughly translates to "total wellness" or "well-being." This refers not just to physical health but carries notions of inner energy and the spirit. This is at the core of Filipino/a/x personhood. Additionally, the KKC is founded in the core value of Kapwa: the notion of a "shared self" that extends the "I" to include the other. It bridges the deepest individual recesses of a person with anyone outside themselves, even total strangers. This holistic, cultural-based, and integrated approach is meant to foster protective factors and improve mental health outcomes for Filipino/a/x youth.

Program Description and Timeline

At the end of the first year, the KKC finds itself moving from the installation stage or start-up phase to the initial implementation stage. The installation stage of implementation saw the program accomplish an incredible amount of work in a short timeframe. Moving from the installation stage, KKC leadership has taken several steps to set the program up for success.

Installation Stage of Implementation

In its first year, the KKC was able to build from the exploration phase of implementation, more commonly known as the proposal stage of grant funding. In the installation phase, the KKC leadership along with their partners were able to achieve:

1. **The creation of infrastructure with stakeholders and youth at the table.** At least once a month, the KKC brought together the BRIDGE Advisory Board to discuss a variety of topics that range from sustainable funding, location for the KKC, to logo designs and community

outreach opportunities, among others. Most critically, the KKC leadership team is also collaborating with the BRIDGE Advisory Board on the services that will be provided once the KKC location is open including:

a. Career Path/Purpose – school-to-career prep
b. Wellness Ambassadors – linkages to wellness and mental health services in the community
c. Rite of Passage Work - cultural identity formation
d. Leadership Development – arts-based projects that will address mental health and wellness related social issues facing the community
e. Youth Production Line and Management financial literacy and wellness
f. Entrepreneurship Skill Building – providing learning opportunities and connections to entrepreneurs in the community to foster creativity and growth

2. **The development of an implementation team with fidelity in mind.** This activity within the installation stage is seen through the evolution of KKC leadership roles and how they are responsive to the strengths, skill sets, and how each growth of each member of leadership. Additionally, KKC leadership began the development of and recruitment for the Kapwa Youth Advisory (KAYA). The recruitment of young people occurred very organically through either word of mouth or outreach by the KKC staff. This group of young people will be advising the KKC leadership team and the BRIDGE Advisory Board on several different areas from service delivery to KKC design and layout. In the second half of the year, the youth attended a leadership retreat, a two-day seminar on entrepreneurship, and attended outreach events.

3. **The identification of needs for work at the community level including the establishment of an advocacy agenda.** Throughout the first year of the program, KKC has done an incredible amount of outreach within the community. Demonstrated through KKC's presence at community events, outreach within the schools to inform youth about the KKC, participation in conferences, and creation of a social media presence. Not only has this level of outreach allowed for the community to learn about KKC but it has also allowed the community to show their support for KKC, exemplified in a fundraising drive in May 2022 when the KKC raised more than $20,000.

4. **The operationalization of the work plan based on a list of startup issues.** The proposal submitted for Mental Health Services Act (MHSA) Innovation (INN) funding outlined the work plan around the list of start-up activities. For example, the proposal timeline included hiring staff – including a Senior Director, Associate Director, and Community Outreach and Engagement Coordinator, identifying the KCC physical location, the purchase of materials and inventory, furniture/equipment, licensing, and permitting. In addition to the identification and securing of the physical location for the KKC, the leadership team also engaged in identifying the design team of architects to manage the renovation to ensure integration of community input on layout, themes, and functionality. This work also included doing outreach to business advisors to engage in discussions regarding the KKC social enterprise business plan and sustainability. Finally, one of the things that KKC leadership has been working on from the initial funding through MHSA INN was how the social enterprise would secure additional funding sources to ensure it became a sustainable social enterprise model and community fixture for young people. With the

approval of Measure K[1] funding in July 2022 for a one-time award of one hundred thousand dollars, the leadership team once again showcased their ingenuity and commitment to their work plan. This funding was used to invest in startup activities, namely for the renovation of the physical space for KKC which included partial construction costs such as interior and exterior modifications, the installation of light fixtures, signage, and furniture.

Implementation Challenges

During the implementation of any new program or innovation, there are going to be challenges or barriers encountered. The KKC experienced both challenges they had anticipated along with unanticipated challenges. The implementation of the KKC is no different. **In the first year, the most significant hurdle that KKC faced was finding a physical location.** In early 2022, KKC leadership, alongside their partners, began negotiations with an indoor Daly City mall as a potential location for KKC. This location sees a lot of foot traffic but as time went on concerns arose over costs, issues with contracting, and the adequacy of the available space for both a KKC and community gathering space.

When it became clear that the mall was not going to be the right option, KKC leadership pivoted immediately to search for additional locations. In late fall of 2021, KKC leadership considered a Daly City-owned space which housed Pat's Closet and met extensively with city council members to ascertain feasibility of this space for KKC. When it became clear that this space was not a viable option, KKC leadership toured other potential spaces including the Alice Bulos Community Center and Daly City Emergency Food Pantry and Dining Center, both in Daly City. KKC leadership ensured to keep the BRIDGE Advisory Board informed of this process at each step of the way and even had them tour one of the spaces. Around this same time, KKC leadership was also involved in conversations with Serramonte Mall management about leasing space while exploring other commercial real estate listings available as well. For all prospective locations, KKC leadership focused most of their energy on time and planning which involved the creation and delivery of presentations, relationship-building, and extensive discussions centered around space negotiations.

After a couple of months of searching for an alternate space, a member of the Filipino/a/x community came forward and discussed with the KKC leadership team that they would be closing their second-generation Filipino/a/x restaurant. They entered negotiations and, in late March 2022, KKC received confirmation that they would enter the lease drafting process for the space. Between April and November 2022, the KKC leadership team has been working with their attorneys to finalize the lease, the permits, have a surveyor take measurements of the space to order equipment and furniture, and have hosted their first community event in the space to introduce the community to KKC.

Apart from difficulties experienced with securing a physical location for KKC, **KKC leadership faced challenges with balancing the duality of their role as both DCP staff members and KKC leaders.** That is, as KKC leadership planned and executed tasks related to KKC they also had to meet the requirements and deliverables as new staff members of DCP such as onboarding. This

[1] Measure K is a San Mateo County half-cent sales tax extension passed by local voters in November 2016 to support essential County services and to maintain or replace critical facilities, providing local funds for local needs. For more information see, **Measure K Frequently Asked Questions**.

entailed learning DCP's systems, reviewing protocols, and establishing relationships with DCP support and administrative staff.

Project timeline delays are also attributable to the backdrop of the COVID-19 pandemic and the shelter-in-place (SIP) ordinance in effect in March 2020 to slow the spread of the virus. In response to this, individual and community health and safety became KKC leadership's highest priorities, thus KKC leadership shifted efforts to focus on well-being needs rather than KKC-related matters. In addition, it was difficult for KKC leadership to successfully navigate the installation and implementation stages of the KKC since the SIP restricted their ability to physically access resources, conduct in-person market research, and engage in site location assessments. Overall, KKC's leadership felt an impact on the level of productivity toward the establishment of the KKC from the pandemic which prolonged its launch.

Initial Implementation

As the first year of the program concludes and KKC moves into year two, the program is moving directly into the initial implementation stage. The delay in securing and setting up the space for operations has pushed out the timeline for the opening from June 2022 to an anticipated soft launch of May 2023. The eleven-month delay has been used to 1) ready the physical space for the KKC, including meeting all necessary licensing and permitting requirements, 2) provide additional leadership training to KAYA to prepare for them for active roles in the KKC; 3) allow additional time for the members of the BRIDGE Advisory Board that will be assisting with planning and/or delivering services in the space; and 3) hire additional staff to manage the space and grow the KKC program.

This will bring an exciting new phase to all those that have been working diligently to see KKC to fruition, but it will also allow for additional areas of data collection that were not possible for the program this year. However, with services planned for 2023, the program is anticipating being able to learn more about what youth need and how KKC can best serve them where they are at.

Evaluation Overview

In November 2021, BHRS contracted RDA to conduct a multi-year evaluation of the KKC. The evaluation intends to:

1. Evaluate implementation, outcomes, and impact of the KKC.
2. Comply with MHSA INN regulatory requirements, including annual evaluation reports to the Mental Health Services Oversight and Accountability Commission (MHSOAC).

RDA conceptualizes its role as evaluation partners rather than external researchers. In this approach, RDA collaborates with BHRS and KKC partners to articulate program goals, develop process and outcome measures, and interpret and respond to evaluation findings. RDA incorporates opportunities for stakeholder participation throughout the evaluation process by including BHRS, the KKC, the BRIDGE Advisory Board, and the KAYA in developing the evaluation plan, reviewing evaluation tools, and interpreting evaluation findings.

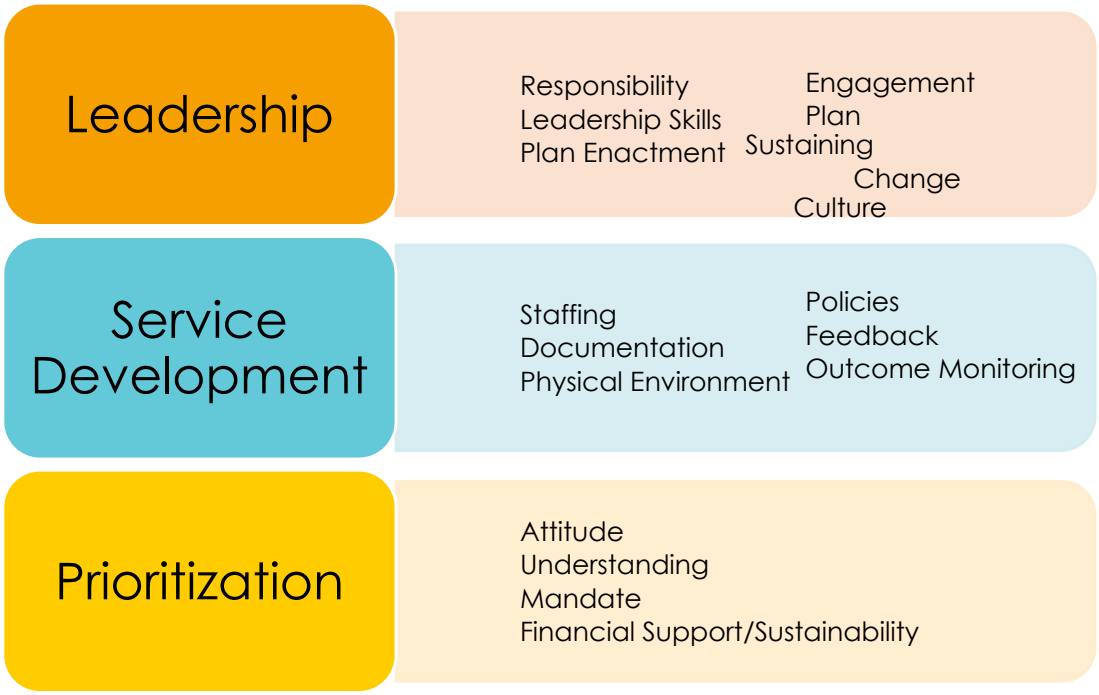
RDA will support KKC program goals through both process and outcome evaluation components. The program evaluation includes assessment of the KKC's development and implementation to support continuous program improvement (process evaluation), as well as the program's outcomes to understand the extent to which intended goals of the program are met (outcome

evaluation). The evaluation will utilize a mixed methods approach, leveraging both qualitative and quantitative data to explore the research questions.

Evaluation Domains

During this first year, RDA focused on three distinct domains of inquiry to evaluate the implementation of the KKC (Figure 1). There were two distinct advantages to this approach. First, this is a crucial time in the implementation process when it is impossible for interventions to stop and take the time to reflect and assess their practices and gather feedback from each other and stakeholders on the progress made toward achieving fidelity to the model they aspire to. Second, the KKC is on a slightly delayed opening timeline which allowed for only a narrow window of data collection in this first year of reporting. However, taking this approach allowed for collection of robust qualitative findings on program development.

Figure 1. Kapwa Kultural Center & Café Evaluation Domains



Leadership

An integral part of the implementation of any program is the leadership component. This domain assesses the impact of leadership on the implementation of the KKC itself. The KKC is guided by a leadership team and BRIDGE Advisory Board since its inception. Using a qualitative data collection process, RDA staff conducted focus groups with KKC leadership, BRIDGE Advisory Board members, and KAYA members to collect feedback on how leadership has guided the process and whether there are opportunities for growth among leaders to support program development and implementation.

Service Development

This domain assesses the program components that impact the day-to-day operations of the KKC. For example, KKC leadership have worked diligently to identify qualifications for the direct-service

positions within the KKC. Understanding the impact of those staffing positions will be helpful for leadership to support future staff expansions or hiring decisions. In addition, this domain considers the crucial role that the physical environment will play in service interactivity. While RDA staff may not be able to make an in-person visit to the site, it is important to understand how the physical layout may or may not create barriers to participation in classes and workshops with sensitive topics.

Prioritization

Incorporating component of KKC's learning goals is to understand how a social enterprise model incorporating youth development and behavioral health programming on-site can impact the lives of young people in a healthy and culturally affirming way. RDA assessed the attitudes and understanding of KKC leadership, BRIDGE Advisory Board members, and KAYA members, using focus groups, to understand the innovative approaches taken to achieve this mission. Simultaneously, RDA recognizes that sustainability is a critical building block of any successful program. Since the KKC intends to serve all youth, regardless of their insurance status, it was necessary to understand the social enterprise business plan that will not only support the startup phase, but the long-term growth of the KKC.

Evaluation Questions

Evaluation questions reflect the purpose of the evaluation, help to guide evaluation activities, ensure the collection of appropriate data, and address local priorities. The questions for the evaluation of KKC are grouped into the three domains described above. Although separated to provide structure for the report process, domains and questions are interconnected and build off each other for a cohesive KKC evaluation.

Leadership

1. To what extent are KKC leadership equipped and empowered to make decisions on behalf of KKC?
2. To what extent are KKC leadership skills and project management valued by the BRIDGE Advisory Board, and KAYA members
3. To what extent has KKC leadership engaged in long-term sustainability planning and included stakeholder engagement in that planning?

Service Development

4. To what level do service delivery staff receive support needed from KKC leadership and the BRIDGE Advisory Board, to implement a culturally affirming model of integrated care for youth?
5. What policies have been developed to guide the day-to-day operations of the services delivered to youth and what plan is in place to complete a Quality Assurance (QA), or Continuous Quality Improvement (CQI) process?

Prioritization

6. To what extent can youth, KAYA, and stakeholders discuss the purpose and mission of KKC? If so, do they feel the work that has been done to date supports the mission?

7. How has the program prioritized the mandate to create a culturally appropriate space for Filipino/a/x youth using a social enterprise model?

Evaluation Methods

Data Collection

Over the course of several planning meetings, RDA and KKC leadership worked together to identify expected measurable outcomes to address each evaluation question that would provide a comprehensive understanding of program activities and outcomes. In collaboration with KKC leadership, RDA then identified appropriate data sources for each outcome measure. **Appendix A** summarizes the evaluation domains, outputs/outcome measures, and corresponding data sources. Given the data collection constraints, to obtain the necessary information to answer the evaluation questions in this first annual report, RDA focused on and utilized only qualitative data sources.

Qualitative Data Sources

KKC Program Documentation: RDA reviewed relevant program documentation to support analysis of the evaluation questions. This documentation included program descriptions, implementation plans, training materials, resource handouts, meeting notes, the social enterprise business plans and other pertinent information provided by BHRS and the KKC stakeholders.

Background Materials & Observation: RDA used extant documents to review, including background materials and relevant communications. RDA also used meetings as opportunities to make additional observations.

Focus Groups: RDA conducted a total of three virtual focus groups between August and September 2022 with KAYA members, BRIDGE Advisory Board members, and KKC leadership (Table 1). KKC leadership and RDA worked together to develop each focus group protocol with each protocol containing a range of 12 to 17 questions. Focus group discussions sought to identify strengths, gaps, and barriers with KKC development and programming, along with understanding stakeholder experience. The length of time for each focus group varied from 60 minutes to 120 minutes and there were three to six participants in each group. The following phrases are used throughout this report to distinguish between focus group participants:

- KAYA members → KAYA focus group participants
- BRIDGE Advisory Board members → BRIDGE Advisory Board focus group participants
- KKC leadership → KKC leadership focus group participants
- KAYA members + BRIDGE Advisory Board members + KKC leadership → All focus group participants

Table 1. Focus Group Descriptions

Focus Group Participants	Total Number of Participants	Total Time in Focus Group (minutes)	Total Number of Questions Asked	Topics Covered
KAYA Members	6	60	14	• KAYA recruitment and orientation • Understanding of KAYA role • KAYA involvement • KKC impact
BRIDGE Advisory Board	5	120	17	• BRIDGE Advisory Board involvement • Role of KKC leadership • Mission-driven innovation • Long-term sustainability of KKC
KKC Leadership	3	90	12	• Leadership role experience • Stakeholder engagement • Mission-driven innovation • Long-term sustainability of KKC

Data Analysis

RDA emphasizes the importance of Continuous Quality Improvement (CQI) as an underlying approach to how data will be analyzed and reported on. RDA conducted data analysis by organizing and cleaning KKC program documentation and background materials, along with the KAYA, BRIDGE Advisory Board, and KKC leadership focus group responses. For future evaluation reports, to analyze the quantitative data, both descriptive and pre-post analyses to describe outcomes as well as to identify changes in knowledge, attitudes, and skills of youth participants both before and after receiving KKC services.

Qualitative data informed both program development and implementation. To analyze qualitative data, RDA transcribed evaluation focus group participants' responses. RDA then thematically analyzed responses to identify recurring themes and key takeaways.

RDA synthesized qualitative findings to learn what aspects of the program are most effective, how to improve, strengthen, and understand the preliminary impacts on KKC youth. Based on these findings, RDA will support KKC leaders in their data-driven decision-making and programmatic improvement efforts.

Evaluation Findings

The following section presents the evaluation findings as they pertain to the evaluation questions mentioned above (see 'Evaluation Questions' for more information). As detailed previously, there were several delays in program implementation which affected service delivery and other program components. Therefore, only evaluation questions tethered to the leadership (EQ1, EQ2, EQ3) and prioritization (EQ6, EQ7) domains could be pursued in this reporting period and their respective findings are detailed below. Evaluation questions related to the service development domain (EQ4, EQ5) will be assessed and incorporated in future reports beginning with year two of program implementation.

Leadership

This subsection describes the impact of leadership on the development and implementation of KKC itself during this first year of program implementation.

EVALUATION QUESTION #1: TO WHAT EXTENT ARE KKC LEADERSHIP EQUIPPED AND EMPOWERED TO MAKE DECISIONS ON BEHALF OF THE KKC?

KKC leadership is hard working, community-focused, and resourceful – deferring to stakeholders and community members when making both large and small decisions. By utilizing a participative leadership style, the leadership team leverages stakeholder expertise, experience, and skill to make well-rounded decisions on behalf of the KKC.

Despite barriers faced at the onset of program development and implementation, KKC leadership have harnessed their individual experiences and external networks to arrive at prompt and sound solutions to overcome several challenges. KKC leadership demonstrated their capability to make decisions on behalf of the KKC by describing the ways they have addressed obstacles during the planning and design phases of the KKC. One challenge identified by KKC leadership involved the business and organizational requirements necessary to create a social enterprise (i.e., a nonprofit entity with a for-profit arm). To run a social enterprise successfully, there were many required partnerships established with an array of professionals, such as lawyers, contractors, consultants, and many more. To achieve this, KKC leadership worked strategically with one another, tapped into existing personal and professional relationships, and formed new bonds with potential stakeholders to create successful partnerships to facilitate the implementation of the social enterprise business model. Another challenge KKC leadership endured was associated with the complexity of KKC's design and how to communicate that to stakeholders and the broader community. Collectively, KKC leadership overcame this challenge by streamlining messaging (e.g., the creation of a brand that embodies the essence of the KKC) and creating a sense of identity that would differentiate KKC from other entities (e.g., sharing the origin of KKC with

stakeholders and allowing them a space to dive into and share their culture). Lastly, KKC leadership shared that there were many instances when the team had to pivot or change course when unexpected difficulties and situations arose. For example, the contractor hired to lead the KAYA retreat could not attend at the last minute. This retreat was integral to launching KKC and, as a result, KKC leadership led the retreat themselves with minimal preparation.

In light of the challenges experienced, **community mobilization and stakeholder engagement were the most prominent successes of KKC leadership.** KKC leadership focus group participants agreed that leadership was able to successfully mobilize the community by generating a lot of interest and support through outreach and the preexisting deep connections leadership has to the Daly City community. Moreover, KKC leadership actively engaged with stakeholders, particularly the BRIDGE Advisory Board and KAYA, to represent the voice of the broader community as well as provide needed expertise and skill. Across all focus group participants, it was clear that KKC leadership relied heavily on their stakeholders when making decisions and sought out their input regularly. Thus, the skill sets of the BRIDGE Advisory Board and KAYA contributed to KKC leadership's ability to make thoughtful decisions on behalf of KKC.

"I feel like a huge part of our accumulated success comes from the ways in which we nurture and foster community within each other."

— KKC Leadership Focus Group Participant

Through KAYA members, KKC leadership ensures that youth voices are heard and woven into all aspects of program decision-making. KAYA focus group participants viewed themselves as ambassadors who connect with youth to spread KKC messaging and shatter mental health stigma. They see this through their advocacy, presence, and messaging to their peers during outreach events and in their lives outside of the KKC. With this as a driving force and support from KKC leadership, KAYA focus group participants feel confident and comfortable representing the youth voice in many of the decisions made by KKC leadership. For example, KAYA focus group participants mentioned that they were heavily involved in tailoring informational materials and messaging towards youth. In addition to youth representation, there were three central skills KAYA focus group participants identified that have and will continue to contribute to the success of KKC: leadership, authenticity, and vulnerability. While there has been a focus for KAYA members to foster their leadership skills, they also have had opportunities to nurture their people skills that assist the implementation of KKC, and the decisions made.

"[Our role as KAYA members is] to make sure the target audience is reached."

— KAYA Focus Group Participant

"I feel like part of the [KAYA] role is to network with other folks, to be ambassadors, to destigmatize mental health, to be involved in creating things and messaging for youth."

— KAYA Focus Group Participant

Along with KAYA, the BRIDGE Advisory Board also provides skills, expertise, and experience that equips the KKC leadership team with making decisions on behalf of the KKC. In the BRIDGE Advisory Board focus group, participants highlighted that their role includes subject matter expertise and capitalizing on strengths of the group for the betterment of the KKC. Participants reported offering experience and expertise in areas such as nonprofit management, advocacy, organizational and strategic development. As KKC is a social enterprise, these skills are undoubtedly valuable when making decisions that involve program development and implementation.

> *"I'd say providing support, advice, and input at each step of KKC development…one meeting might be about the logo, securing more funding, etc.…Lending my voice and expertise…Everyone contributing our strengths is how we come together."*
>
> — *BRIDGE Advisory Board Focus Group Participant*

EVALUATION QUESTION #2: TO WHAT EXTENT ARE KKC LEADERSHIP SKILLS AND PROJECT MANAGEMENT VALUED BY THE BRIDGE ADVISORY BOARD, KAYA MEMBERS, AND OTHER STAKEHOLDERS?

Stakeholders value KKC leadership skills and project management as it is grounded in community involvement, transparency, efficiency, and relationship-building. In a focus group discussion, BRIDGE Advisory Board members were overwhelmingly positive about the leadership team and felt that the team had many strengths contributing to the success of the KKC. Firstly, there was a consensus among all participants that the leadership team has done well with the development and implementation of KKC. The original proposal was community-focused, the team made the right connections needed to move the program forward, and program activities were regularly ahead of schedule. Participants noted that the leadership team was able to achieve this by working hard and planning well, which contributed to success both during and after the COVID-19 pandemic. Additionally, one focus group participant noted that the leadership team was intentionally transparent in the planning and design of KKC. For example, the leadership team acknowledged when they did not know something and always reached out for support when needed, especially from stakeholders. A central element of KKC leadership has been stakeholder engagement, highly valued by both KAYA and BRIDGE Advisory Board members.

> *"I'll add to the heart they are passionate about what they do and caring of us as individuals, which is definitely a big thing for us…and along with the strengths, if they don't know something they ask and figure out who to bring in to assist them…they don't know everything [about] the business side of running a business so they've brought in so many other people to give them information or assistance"*

— BRIDGE Advisory Board Focus Group Participant

KKC leadership not only blends youth voice into a range of program decisions but also boosts KAYA members' confidence in their decision-making abilities and holds their input to high regard. In the KAYA focus group, one participant emphasized that KKC leadership includes them in the "dialogue for big and small decisions." Focus group participants also underscored that KKC leadership values their input. For example, a focus group participant shared that in their experience with other organizations youth voice is often ignored, highlighting that with KKC, "There has never been a time when their voices have been thrown aside." Prior to joining KAYA, focus group participants felt uncertain and at times doubted their capabilities to use their knowledge and contribute their ideas to inform KKC programming and development. However, after speaking with the KKC Outreach and Engagement Coordinator, these participants left the conversation feeling nurtured, understood, supported, and empowered. The KKC Outreach and Engagement Coordinator helped these participants to realize that the difference they wanted to make in their community was attainable and that their opinions mattered.

According to KAYA focus group participants, the KKC Outreach and Engagement Coordinator for KKC places enormous value on KAYA members' voices and their culture which has increased their confidence. Most notably, focus group participants were both surprised and grateful that their feedback was respected and incorporated in KKC decisions as this has not been the case in some participants' prior experiences with other organizations. In fact, focus group participants viewed this as the greatest strength of KKC and KAYA. That is, the ability of KKC leadership and the BRIDGE Advisory Board to not only share the decision-making space with KAYA members but also treat them as equals.

Like KAYA focus group participants, BRIDGE Advisory Board focus group participants voiced similar sentiments regarding KKC leadership's focus on stakeholder engagement. Overall, focus group participants expressed that there is very strong involvement and connectedness with the KKC leadership team. Focus group participants expressed that the KKC leadership team actively listens to them and takes their input very seriously.

Relationship-building is also a top priority for KKC leadership, and their efforts are well-received by KAYA members and BRIDGE Advisory Board members alike. Along with inviting KAYA members to participate in decision-making, KKC leadership prioritized relationship building. Focus group participants expressed deep admiration for the manner in which the KKC Outreach and Engagement Coordinator took the time to get to know them as individuals, relate to them, and lead with care and vulnerability. This truly resonated with the focus group participants and has largely influenced the way in which they will lead in the future.

"[The KKC Outreach and Engagement Coordinator] humanizes the word leadership. She really wants to know us rather than our resumé. She doesn't make us feel like we have to be the best of the best all the time. She just wants us to be our authentic selves. She provides a vulnerable feeling for the whole group to be ourselves and talk about anything. I have learned a lot from her as a leader. Being vulnerable is always a plus."

— KAYA Focus Group Participant

Similar to what was said in the focus group with KAYA members, the BRIDGE Advisory Group also felt that the KKC leadership team's care for stakeholders is a big strength. Participants noted that the KKC leadership team cares for the BRIDGE Advisory Board as individuals and actively creates a culture where members feel safe to share. Through the personal relationship-building that KKC leadership fosters, participants realized that they all have similar goals and motivations to KKC leaders and the KKC mission, which creates a sense of identity and unity among the group.

Apart from engaging KAYA and BRIDGE Advisory Board members in the decision-making process, **KKC leadership takes the time to get to know them on a deeper level and understand how their individual strengths can be maximized.** This generates a greater sense of comfortability for BRIDGE Advisory Board members to provide ongoing conducive feedback to KKC leaders . BRIDGE Advisory Board focus group participants noted that the team consistently seeks out feedback from the board through brainstorming sessions that use targeted techniques such as breakout exercises, feedback cycles, and post-meeting reach out, to elicit feedback. Furthermore, participants discussed that the KKC leadership team has made a concerted effort to report updates to the board and if there were any tasks that needed to be done, the KKC leadership team looked to the strengths of individual BRIDGE Advisory Board members to fill those needs. By doing this, BRIDGE Advisory Board members have felt that they are positively contributing to the development of KKC and view this collaboration as fun and enjoyable.

"It's like we're a very functional family. We come together and when there's no projects there's no grudges or drama. We have fun together and we work together, and we make things happen."

— BRIDGE Advisory Board Focus Group Participant

"The leadership has made good use of the BRIDGE Advisory Board and has been effective in making us feel we have a say in informing KKC and programming…"

— BRIDGE Advisory Board Focus Group Participant

EVALUATION QUESTION #3: TO WHAT EXTENT HAS KKC LEADERSHIP ENGAGED IN LONG-TERM SUSTAINABILITY PLANNING AND INCLUDED STAKEHOLDER ENGAGEMENT IN THAT PLANNING?

KKC leadership has demonstrated an interest in long-term sustainability and has begun planning. Stakeholders are aware of sustainability planning and KKC leadership is continuing to strengthen stakeholder engagement to include KAYA and BRIDGE Advisory Board members in decision-making for years to come.

BRIDGE Advisory Board members view KKC leadership as forward-thinking in terms of sustainability planning and profoundly committed to this effort. In the BRIDGE Advisory Board focus group, participants were aware that the leadership team was engaging in long-term sustainability planning. One focus group participant noted that the leadership team has expressed a desire to evolve the KKC – the leadership would like the KKC to move from a storefront building to an expansive cultural community space beyond the initial five years of funding. With the KKC being

in a centralized location, there is promise of sustainability. Additionally, the same participant noted that the leadership team has been and continues to be committed, showing a lot of grit and ambition in bringing the KKC to life. The leadership team's commitment is displayed through the relationships they have created with stakeholders and a focus group participant affirmed that this type of leadership brings about mental and emotional stability in the long-term. Lastly, another focus group participant noted that the leadership team is aware of the need for different funding streams and has taken steps to find those opportunities for long-term sustainability after the innovation pilot term ends.

Aside from the diversification of funding streams, KKC leadership understands that a more comprehensive strategy is needed to produce an effective sustainability plan. The BRIDGE Advisory Board's understanding of KKC leadership's engagement in long-term sustainability planning was confirmed and expanded upon in the focus group discussion with members of the KKC leadership team. In the focus group discussion, KKC leadership expressed that to promote sustainability, the team needs to elicit stakeholder feedback, diversify funding streams, and redefine sustainability. Focus group participants raised concern over the need for increased stakeholder feedback moving forward into the future of the KKC. Although focus group participants noted that KAYA and the BRIDGE Advisory Board were heavily involved in the planning process, time is now very limited and makes it difficult to continue making space for that level of ongoing stakeholder feedback. A focus group participant noted that meetings have been scaled down to every other week, which only allows time for KKC leadership to share updates and plan next steps. KKC leadership expressed that they hope to have a better system in place to elicit ongoing stakeholder feedback in the future. Additionally, a focus group participant noted that seeking out diverse funding streams, such as a passive income stream, is crucial for long-term sustainability. This same participant also emphasized that the KKC's sustainability is not entirely economic. The KKC's mission is to help youth prosper as citizens and community members through learning hard skills and connecting with others. Thus, the KKC is sustainable in nature because its mission benefits youth and ultimately the community for years to come. This new definition of sustainability is valued by the leadership team and drives their work forward into the future.

> *"It's also in how sustainability is defined and looking at the impact beyond economic sustainability. We are doing the whole "trying to teach to fish" [method]. We need to be building sustainable citizens and we are trying to find loopholes from traditional pathways by providing expansive and plentiful options to build their capacity. Creating a space where the community can learn hard skills is sustainability."*
>
> *— Focus Group Participant*

Prioritization

This subsection articulates how KKC, a social enterprise, can support the work of impacting the lives of young people in a healthy and culturally affirming way. This section also reveals how stakeholders view the mission of KKC and whether steps have been taken to achieve this mission.

EVALUATION QUESTION #6: TO WHAT EXTENT CAN KAYA AND BRIDGE ADVISORY BOARD MEMBERS DISCUSS THE PURPOSE AND MISSION OF KKC?

The BRIDGE Advisory Board and KAYA members had similar views on what the mission of KKC is aimed to achieve, expressing that the KKC's mission is centered around youth, leadership, culture, and mental health. These sentiments were in line with how the KKC leadership team described the mission of KKC, pointing to a sense of unity and mutual understanding across.

The BRIDGE **Advisory Board and KAYA members view KKC as a space for mental health services, leadership skill building, and cultural pride, all of which will be demonstrated through youth's current and future experiences and endeavors.** In the BRIDGE Advisory Board focus group, participants had similar mission statements for KKC. Generally, focus group participants expressed that KKC is a space that provides youth with mental health services, as well as opportunities for learning and growing as entrepreneurs and leaders. Moreover, focus group participants noted that the mission of KKC will be achieved "one youth at a time." In the end, the KKC will know it was successful in its mission through the youth, themselves. Ideally, youth that become entrepreneurs or hold leadership roles as adults can come back to the KKC and talk about their experience.

In addition to the KKC's focus on building leadership skills, KAYA focus group participants emphasized KKC's power to evoke a sense of belonging and cultivate cultural pride. In a space like KKC, youth will be able to use the KKC to "explore their culture at their own pace" and individualize their experiences.

The way the BRIDGE Advisory Board and KAYA members described the purpose and mission of KKC is consistent with the views held by the KKC leadership team, illustrating KKC as a hub for holistic wellbeing. In the leadership focus group discussion, participants were able to discuss the importance of meeting the mission of the KKC and the impact that it will have on youth for years to come.

"The mission of KKC is to offer culturally affirming services whether that be mental health development or in leadership entrepreneurship and bring in the intergenerational aspect of it which is important to the Filipino community and making sure it's very open, welcoming and in the spirit of Kapwa."

— BRIDGE Advisory Board Focus Group Participant

"The Kultural Center is a location where young people can feel empowered, gain skills, and connect with Filipino culture."

— BRIDGE Advisory Group Focus Group Participant

EVALUATION QUESTION #7: HOW HAS THE PROGRAM PRIORITIZED THE MANDATE TO CREATE A CULTURALLY APPROPRIATE SPACE FOR FILIPINO/A/X YOUTH?

KKC leadership recognizes the significance culture plays in influencing positive change and infuses it into each element of the program, including the physical space. There was a unanimous assertion from all focus groups that KKC prioritizes the goal of creating a culturally appropriate space for Filipino/a/x youth. The BRIDGE Advisory Board focus group said it best, noting that culture is the undercurrent that influences all aspects of KKC. Specifically, participants expressed that leadership, mental health, skill-building, and all other components of KKC are rooted in Filipino/a/x culture. KAYA members and KKC leadership also agree that culture is at the heart of the KKC's mission and at the center of all programming. Through the focus group discussions, KAYA members and KKC leadership elaborate on how the KKC is a place for youth to connect with their culture and with their community through food, art, and wellness.

"KKC is a community wellness model for leadership empowerment and cultural resilience and celebrating our place in the world, our history of resilience (and taking pride in that), and that we are part of this community, and we are also part of our roots in the Philippines."

— BRIDGE Advisory Board Focus Group Participant

KAYA focus group participants firmly believe in KKC's ability to cultivate cultural pride, which can serve as a protective factor for mental health and has the power to ameliorate shame tied to colonialism and build confidence among Filipino/a/x youth. As said prior, focus group participants feel as though youth will be able to use the KKC to "explore their culture at their own pace" and individualize their experiences. As an example of this, focus group participants mentioned that youth will have the opportunity to take part in various discussions about mental health and culture, including the impacts of colonialism and stereotypes on these topics. In turn, focus group participants hope that this will destigmatize mental health, break down colonial mentality, and reinforce and enhance cultural pride and traditional practices. To this point, focus group participants elevated an iteration of Dr. Jose Rizal's famous quote, "No history, no self. Know history, know self." Focus group participants reiterated the detrimental effects that colonization continues to have on the mental health of Filipino/a/x youths, emphasizing that it perpetuates a feeling of being ashamed of where they come from which leads to internalization. This internalization then exacerbates these youths' feelings of suicidal ideation, low self-esteem, depression, and many other mental health conditions. With culture and wellness as one of the main components of KKC programming, focus group participants articulated that youth will be able to interact with a multitude of services that will help to inform and shape their cultural identity and, consequently, address their mental health needs. One focus group participant voiced that as a KAYA member, they already feel a sense of belonging and, with time, their "Filipino-ness" will only be amplified, building up their confidence to take up space "as a Filipino woman."

"With programs like [KKC], it is possible to have a better understanding of yourself and your history and your people and you can impact what you have now."

— KAYA Focus Group Participant

KKC leadership believes the program is a culturally appropriate space for Filipino/a/x youth because the KKC prioritizes relationship building and connection through art, food, and wellness. As said prior, the leadership team views the KKC as a place to help youth and the general community experience holistic wellbeing and cultural healing. Focus group participants expressed that the KKC achieves this mission through art, food, and wellness. By creating a space for gathering with art and food at the KKC, people are drawn together and can connect. Focus group participants also noted that the KKC is a multi-functional space that has the capacity to host a variety of events, such as cooking and movement classes, open mic nights, as well as other workshops that promote wellness and honor Filipino/a/x culture.

"Words that come to mind [include] community, connection, ancestral healing, and preservation of our culture."

— Leadership Focus Group Participant

Key Program and Operational Learnings

KKC and the additional partners that compose the implementation team, have been working to see KKC successfully implemented in the first year have made great implementation progress. Some of the implementation efforts and accomplishments by the KCC team under the MHSA INN grant during the year were:

- Key KKC staff were hired…
- A site was chosen with the permit process underway and design plans being finalized.
- The implementation team meets at least once a month, with KKC leadership meeting with the BRIDGE Advisory Board, and evaluators in addition to the implementation team.
- KKC leadership successfully recruited an incredibly engaged and invested KAYA group with young people committed to creating space that will serve their community.
- An evaluation plan that is meant to grow with the program to assess the program at each stage of implementation has been designed will be revisited each year to ensure it meets the program where it is at for the upcoming year.

In this section of the report, important lessons learned from the planning and implementation process are highlighted to support similar initiatives and programs. They also address evaluation questions related to success and challenges of implementation. These learnings were compiled from implementation meetings and data collection efforts.

Lesson: Program start-ups for innovative and complex programs require substantial time and commitment

- Implementation of an innovative program comes with programmatic decisions, processes, and requirements to plan for. Given the complexity of the program, a social enterprise incorporating behavioral health and youth development programming, the many stakeholders and layers of decision-making, the installation and initial implementation process has been long and at times difficult. For example, the delay in having access to the physical space has required leadership creativity and effort to keep momentum for

the project. Setting benchmarks and timelines can assist with the identification of tasks and what is needed for sustainability.

Lesson: The commitment to creating space with and not for the community takes organization and a reliance on others to carry the mission forward.

- A critical component of the KKC is ensuring that young people have a place to be seen and heard within their community. Similarly, the Filipino community values the voice of all generations and KKC brings that to the program with KAYA and the BRIDGE Advisory group. This has expanded the implementation working group for the KKC. While this does create a larger working group, which creates its own set of challenges, it also means that the program has many more resources to work with to make the program the best that it can be. It is important that KKC leadership seize these opportunities and share the responsibilities with those that are invested in the successful implementation of the program.

Program Changes From Initial Design

KKC leadership did make several pivots throughout the first year of implementation. However, there has not been a significant impact on program design. The biggest impact that the program is anticipating as the program moves into year two is that the piloting of services currently under development may need to be held in alternate physical locations as the setup of the KKC physical location is completed.

Future Directions

In the second year of the program, FY22-23, KKC will continue to finalize site plans with an expected soft launch in May 2023. While KKC awaits their site to be completed, the program will be piloting the first round of services to youth. The plan is to offer these services at borrowed spaces located in their partner's locations (i.e., Daly City Partnership, Daly City Youth Health Center, etc.). Additionally, KKC leadership will be engaged in hiring additional staff for case management as well as to manage the day-to-day operations of the KKC, the social enterprise component of KKC. Finally, KKC has plans to continue to engage with the community through attendance at outreach events, hosting events, and engaging with the KAYA group.

Appendix A.

Evaluation Domains, Outcome Measures, and Data Sources

Appendix A. Evaluation Domains, Outputs and Outcome Measures, and Data Sources

Evaluation Domain		Outputs and Outcome Measures	Data Sources
Leadership	*Evaluation Question #1:* To what extent are KKC leadership equipped and empowered to make decisions on behalf of the KKC?		
	Responsibility & Plan Enactment	• Ability to meet project deadlines • Accounting of delays in progress toward opening • Implementation successes & challenges	• Focus Groups • Program Documents • Background/Observation
	Evaluation Question #2: To what extent are KKC leadership skills and project management valued by the BRIDGE Advisory Board, KAYA members, and other stakeholders?		
	Leadership Skills & Engagement	• Stakeholder satisfaction overall and with leadership • Clarity and transparency among stakeholders • Diverse stakeholders and support	• Focus Groups • Program Documents
	Evaluation Question #3: To what extent has leadership engaged in long-term sustainability planning and included stakeholder engagement in that planning?		
	Plan Sustaining	• Collaboration and communication (changes, successes, challenges) • Social enterprise business plan updates to reflect ongoing communication and feedback	• Focus Groups • Program Documents
Service Delivery	*Evaluation Question #4:* To what level do service delivery staff receive support needed from KKC leadership and the BRIDGE Advisory Board, to implement a culturally affirming model of integrated care for youth?		
	Staffing, Physical Environment, & Documentation	• Staff satisfaction • Youth satisfaction • Youth voice within services	• Youth surveys • Focus Groups • Program Documents

Evaluation Domain		Outputs and Outcome Measures	Data Sources
	Evaluation Question #5: What policies have been developed to guide the day-to-day operations of the services delivered to youth and what plan is in place to complete a QA, or CQI process?		
	Policies, Feedback, & Outcome Monitoring	• Impact of policies • Evidence of change from monitoring and feedback	• Focus Groups • Program Documents
Prioritization	*Evaluation Question #6:* To what extent can KAYA, and BRIDGE Advisory Board members discuss the purpose and mission of KKC? If so, do they feel as though that mission is being accomplished?		
	Attitude & Understanding	• Project awareness across stakeholders and youth	• Focus Groups • Program Documents
	Evaluation Question #7: How has the program prioritized the mandate to create a culturally appropriate space for Filipino/a/x youth using a social enterprise model?		
	Mandate & Financial Support / sustainability	• Space evaluation by stakeholders and youth • Impact of funding sources and model on services	• Focus Groups • Program Documents

APPENDIX 12. CONTRACTORS ASSOCIATION REPORT, FY 2021-22

NEEDS ADDRESSED BY FUNDING

CONTRACTOR	Amount Granted	Amount Spent	Improved capacity to provide integrated models for addressing trauma and co-occurring disorders	Improved capacity to incorporate evidence-based practices into day-to-day resources	Improved cultural competency	Improved capability to collaborate, partner and share resources and information with other Association Members	% of Funding Recipients' staff who provide direct services participated in training that developed new skills in the areas of trauma, co-occurring disorders and/or cultural awareness	Comments
Art Unity Movement	$4,651	$5,345.20	Yes	Yes	No	Yes	75%	Outcome accomplished. Most participants reported that their stress was lower at the end of the session, often significantly so. During the session there was a sense of collaboration and comradery. Participants report having incorporated what they learned into their personal and professional lives. Speaker fee 2 x $110.00 per hour 2.5 hours=$550.00 X 5 sessions=$2750.00 Preparation: 20 hours $2,000 Travel/Site rental/Miscellaneous: $250.00 Workshop Materials for both Presentation and Experiential Portions: $459.44 Mileage: $88.69 Total: 5548.13 $ 5345.20 MHSA $ In Kind $202.93
California Clubhouse	$4,651	$4,724.00	No	Yes	No	No	75%	Our MHSA 2021-2022 grant proposal included providing our staff of seven (7) with professional development training that willsupport them in their respective roles at California Clubhouse. Given that our program is unique in that staff have the opportunity to work side-by-side with members (clients), we strongly believe it is beneficial to provide trianing to our entire staffing - program and administrative. Our original proposal included Motivational Interviewing: the Language of Change an donline calss with Dr. Stephen Rollnick and Ethics of Storytelling training by Markkula Center for Applied Ethics. However, afte further research, we gelt it was more adequate to contract with a trainer on Motivational Interviewing that the county has used in the past. The information on Kristin Dempsey was shared by Claudia Saggese and Erica Burton. Apart from that, we had a difficult time dining an Ethical Storytelling training through Markkula Center of Applied Ethics. Therefore we had to pivot our direction and find a training that would benefit our community just as much. We went ahead and asked staff to register to attend the Conflict Resolution with Power and Privilege in mind. this traning aligns well with our Cubhouse model as well as our counties stance on peer support. With both these trainings, California Clubhouse staff will be better prepared to provide support to member (clients) in both their personal and professionla lifesby sharing skills gained through the training. This, in turn, will allow our members to gain or revisit skills that will empower thme to be active participants in their own recovery and in the greater community. Please note that 100 percent of our employees attended the following trainings: Conflict Resolution with Power and Privilege in Mind: $250/person for 7 = $1750 Motivational Interviewing: 6 hour session at $2724.00 Centering People During Organizational Change and Transitio = $250.00

CONTRACTOR	Amount Granted	Amount Spent	Improved capacity to provide integrated models for addressing trauma and co-occurring disorders	Improved capacity to incorporate evidence-based practices into day-to-day resources	Improved cultural competency	Improved capability to collaborate, partner and share resources and information with other Association Members	% of Funding Recipients' staff who provide direct services participated in training that developed new skills in the areas of trauma, co-occurring disorders and/or cultural awareness	Comments
Caminar	4650.75	5350	Yes	Yes	Yes	Yes	100%	CASRA on February 9th and April 20th 35 participants •35 staff out 40 were trained for a 87.5% trained Pro-Act Training (Professional Assault Training)– Trainers Anthony Garcia and Melissa Fisher 8/23-24, 9/15-16, 10/7-8, 10/21-22, 11/8-9, 1/3-5, 3/7 & 3/9, 6/5-12 •85 staff out of 91 were trained for 93% trained Monthly MI Labs Training – Trainer-Chris Dirks, April 6th & April 7th 8 •25 out of 85 staff were trained for 29% trained to date Open FIT Data Training – Trainer-Enda Madden on March 14th and 31st 55 participants •55 staff out 85 staff were trained for 65% trained FIT Implementers Training – Trainer-Rikke Addis on March 8th 60 participants •60 staff were in attendance for approximately 70% trained to date Exploring Culture and Identity/Caminar's Employee & Client Focused Resource Fair- June 15, 2022 •Open to all staff of 85. This training has not yet begun. Staff are strongly urged to attend. 02/9-04/20 CASRA (no cost) 8/23-24, 9/15-16, 10/7-8, 10/21-22, 11/8-9, 1/3-5, 3/7 & 3/9, 6/5-12 Pro-Act Training Trainers Anthony Garcia and Melissa Fisher (Caminar trainers at no cost) April 6th & April 7th 8 Monthly MI Labs Training – Trainer-Chris Dirk, (Caminar trainers at no cost) March 14th and 31st Open FIT Data Training – Trainer-Enda Madden @ $1200 March 8th FIT Implementers Training – Trainer-Rikke Addis @$300 June 15th Exploring Culture and Identity/Caminar's Employee & Client Focused Resource Fair- June 15, 2022 DI-Nancy Khan-trainer $2800, Art Unity Movement trainers $750, Bay Area Music Therapy trainer $250 Gift cards for the training (people bingo, 2 people) $50 Total $3850 $4.80 Caminar in-kin contribution
Children's Health Council	4650.75	5345.2	Yes	Yes	Yes	No	75%	100% of clinicians participated in this training $3000.00 (speaker fee) $694.45 (speaker fee) $1650.75 (materials / supplies)
Daly City Youth Health Center	4650.75	5345.2	Yes	Yes	No	No	75%	supervision. All have begun to use EMDR with clients to treat trauma. Clinicians overwhelmingly reported positive feedback regarding the training. Comments such as "I feel like this is the first training I have ever attended where I actually learned something I can use right away and with confidence" and "I am so excited about using this with clients. If I didn't experience it myself during training I would not have believed it. It works like magic.". It is too early to be able to report valid treatment results but we are very optimistic about being able to use EMDR effectively for trauma treatment with clients of all ages. We will be investing in bilateral stimulation equipment as we plan to incorporate this Evidence Based Practice into our preferred treatment toolbox.

CONTRACTOR	Amount Granted	Amount Spent	Improved capacity to provide integrated models for addressing trauma and co-occurring disorders	Improved capacity to incorporate evidence-based practices into day-to-day resources	Improved cultural competency	Improved capability to collaborate, partner and share resources and information with other Association Members	% of Funding Recipients' staff who provide direct services participated in training that developed new skills in the areas of trauma, co-occurring disorders and/or cultural awareness	Comments
Edgewood	4377.17	7000	No	No	Yes	No	75%	Outputs: - 74% of the regiona's 70 employees participated in the 4-hour Creating & Sustaining and Anti-Oppressive Community training on Tuesday, April 26, 2022, facilitated by Natalie Thoreson. - 70% of the region's 70 employees participated in the 4-hour Challenging Heterosexism training on Thursday, April 28, 2021, facilitated by Natalie Thoreson. - 95% of attendees rated these two trainings "excellent" or "very good". - Following the two trainings, a few employees who identify as members of the LGBTQ+ community are planning to host a "Beyond the Rainbow" panel for all Edgewood employees as a way to continue the dialogue of creating more inclusive practices for our employees and clients. - As of June 24, 2022, 61 of the 69 employees (88%) completed at least 8 hours of Diversity, Equity and Inclusion training hours. $7,000 for external trainer, Natalie Thoreson. Cost included prep, materials, and 16-hours of training time.
El Centro de Libertad	4650.75	5500	Yes	No	Yes	No	75%	2-day coohorts provided - Intro to Motivational Interviewing and Advanced Interrviewing; staff who attended increased their capacity to incorporate evidence-based practices in the day-to-day treatment; other organization members were invited; spent $5500
Felton	4377.17	4377.17	Yes	Yes	Yes	Yes	100%	Objective #1 - By the end of FY 21-22, a minimum of 75% of staff members (8 out of 10) of Felton Institute programs in San Mateo County - (re)MIND, BEAM and (re)MIND Alumni - will attend and participate in approved training in trauma, co-occurring disorders and/or cultural responsiveness topics. ACHIEVED - During FY 21-22, the following training opportunities were made available to Felton Institute staff at programs - (re)MIND, BEAM, (re)MIND Alumni programs to meet the needs addressed with this grant funding. A total of 10 out of 10 staff (100%) participated in at least one grant-sponsored training or capacity building activities. These activities included live online or hybrid training sessions with verified attendance and/or completion of assigned on-demand trainings. All monies were spent in their entirety by the date of this report (6/30/22). ** Cognitive Behavioral Therapy for Psychosis (CBTp) - $3000 ** Contracted to Riggs Psychology, PLLC for CBT for First Episode Psychosis hybrid training. Live training sessions in March 2022, and additional bi-monthly sessions through June 30, 2022. ** Evidence-Based Approaches to Bipolar and Other Mood Disorders - $800 ** Monthly sessions provided between 7/1/21 - 6/30/22 by Dr. Descartes Li (UCSF) ** Harm Reduction/Co-Occurring Disorders and Cultural Responsiveness Trainings - $577.17 ** Trauma-Focused CBT On-Demand Training by Medical University of South Carolina ($245) 3/10/22 - "Understanding Early Psychosis and Racially-Informed Mental Health Care" ($600 - registration fo six staff members) 3/11/22 - "Feeling Safe Program" - live virtual training by ISPS on trauma and psychosis ($40) 9/3/21 - "Harm Reduction Therapy for Substance Use Disorders: Basic Principles and Strategies" by Dr. Phillip Tsui, PsyD (7hrs) 2/11/22 - "Working with Immigrants and Their Families: Psychosocial and Therapeutic Issues" by Dr. Phillip Tsui, PsyD (7hrs) 3/18/22 - "Dual Disorder of Substance Abuse and Mental Illness— Diagnostic and Treatment Issues" by Dr. Phillip Tsui, PsyD (7hrs) 3/11/22 - "Feeling Safe Program" - live virtual training by ISPS on trauma and psychosis ($40) (Invoices and other supporting documents available upon request)

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Fred Finch Youth Center	4377.17						75%	Consultation with Taquelia Washington re racial equity visioning/planning Trainings: Seeds of Change- About the Effects of Living with Uncertainty Ninety Two percent of staff attended (12 staff) Attachment Regulation Competency (ARC)- Trauma Informed services training Ninety two percent of staff attended (12 staff) Developing Mindfulness Tools to Prevent Vicarious Trauma for support Ninety two percent of staff attended (12 staff) T. Washington $150 AUM lunch $281.43 ARC training $1,012.50 + lunch $410.70 Mindfulness $1478.58 + Lunch $641.32 + Breakfast $221.23 Books and training materials $897.56 Total $5093.31
Free At Last	4650.75	5093.31	Yes	No	Yes	Yes	75%	Free At Last conducted a training workshop with the topic of Cultural Competence on 4/18/22. We had 89% or 17 of 19 of Free At Last staff who participated in the training increased their knowledge and or skills to assist them with their work. We had 89% or 17 of 19 of Free At Last staff who participated in the training saw the value in the training. Paid for a trainer or consultant to facilitate the training) $2,400.00 Paid for part time staff to come in for time beyond their normal hours. Staff time/benefits 10 part time staff x 8 hours x$23.40 1,872.00 Food (Snacks, drinks, and lunch) 378.75 $4,650.75
Health Right 360	4650.75	4650.75	Yes	Yes	Yes	No	75%	We had 16 staff attend various trainings hosted by National Harm Reduction Coalition. The training topics were as follows: Harm Reduction, Trauma and Substance Use, Introduction to Motivational Interviewing, and Advanced Motivational Interviewing. The training series was concluded with an NHRC Office Hour, where staff were able to ask questions about all the training topics and get feedback on clinical scenarios where we incorporate harm reduction, trauma-informed care, and MI. These trainings provided education and practice opportunities to learn how to incorporate these aspects of evidence-based care into our everyday work. Feedback on the trainings has been very positive, with many staff reporting a better understanding of harm reduction and MI in particular. Grant Budget Total: $4,650.75 NHRC Training Series Cost: ($4,700.00) Covered by HR360: ($49.25)
Heart and Soul	4377.17	1118	No	No	Yes	No	75%	Continued to have a Cultural Competency Committee that provided trainings to the staff We intended to hire someone to do a cultural competency workshop, but were unable to in the time frame, we still intend to use the rest of these funds to hire a cultural competency trainer. 1118.00 was spent on staff wages during additional hours spent on the cultural competency committee

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Mental Health Association	4650.75	5345.2	No	No	Yes	Yes	75%	MHA hosted three virtual education events during FY 2021/22 focused on increasing understanding. The first featured Dr. Cassandra Joubert who spoke about her book, "Losing Control: Loving a Black Child with BiPolar Disorder", and her life experiences as the mother of a child with a mental illness. The second featured Shonda Buchanan who spoke about her book, "Black Indian", and focused on generational trauma and its impact on mental health. The third featured Dr. Alex Korb, a neuroscientist whose presentation focused on using Neuroscience to address issues related to depression. 90%, or 45 of MHA staff participated in these events. Speakers Fees: $5,500 MHA contribution: $154.80 MHSA Grant Used: $5,345.20
Puente	4650.75	5345.2	Yes	No	Yes	No	75%	Objective #1: 21 (75%) staff will engage in resilience and wellness strategies through trauma informed/ cultural humility training during staff meetings Outcome: 28 (100%) staff engaged in resilience and wellness strategies during the two staff-focused Trauma 101 virtual trainings this spring. These strategies include sharing their experiences during the pandemic within a trauma-informed activity; practicing mindful breathing and movement; identifying culturally specific self-care practices that they would like to do more to build resilience; and making commitments about simple activities that they would like to revive or do that involve connecting with their positive supports and community. Additionally, an average of 10 (40%) staff regularly engage in voluntary trauma-informed and culturally aware mindfulness sessions before all virtual staff meetings. Objective #2: All (100%) of Community Mental Health and Wellness staff will be trained to provide these practices Outcome: All three (100%) CMHW staff received training in trauma-informed and culturally aware mindfulness practices during this grant period. Additionally, all three have engaged staff and community members in these practices during the grant period. Objective #3: Three (3) Trauma 101 workshops and wellness kits will be offered to the community Outcome: One (1) Trauma 101 virtual workshop in Spanish was offered to the childcare provider community through San Mateo County First 5 and two (2) Trauma 101 virtual workshops were offered to Puente staff in English with simultaneous Spanish interpretation; Wellness Kits, which included sensory-based items to support resilience and self-care, were offered during the Puente staff virtual workshops. Fifteen (15) people registered and six (6) attended the First 5 Trauma 101 training in Spanish on 04/28/22; many of those who did not attend said they forgot about the training, even with multiple reminders, perhaps indicating the need for more of these trainings. After this training, we shifted our focus to Puente staff as attendees, primarily because these sessions were designed to be an initial exploration into understanding trauma within a cultural humilty lens. Given that the majority of Puente staff live in the community, they have had to endure the last two years of the pandemic, the CZU fires, and ongoing racial and ethnic discrimination and injustice themselves, this shift supported best practices in this work of starting with the self before helping others. We found that while

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Service League	4377.17	4377.17	Yes	Yes	Yes	No	75%	#1 - SOGI/LGBTQ+ 101 #2 - Transgender 101 #3 - Correct Pronouns 101 #4 - Best Practices, working with Latinx Populations #5 - Best Practices, working with AAPI Populations All classes were 2 hours in length and were attended by staff from all of the various shifts at our 24-hour facility. Additionally, we invited our instructors and volunteers to attend. The main focus of this year's training series was SOGI topics which provided participants with an increased knowledge of evidence-based cultural competency, especially in this area. As a co-occurring program, these trainings will assist all staff including our administrative staff to better understand the challenges that many of our clients face in their lives. Measurable Objectives were met: Because all training was provided via Zoom, it was feasible for a higher number of staff to attend. We were able to have 10 staff members attend each of the 5 trainings, 4 of whom were clinical staff. In addition, we had at least 2 volunteers and instructors in attendance for each training. Most of the staff members and volunteers were able to attend the trainings in person at our facility, which was a great change for this year. Lunch was provided and discussion groups followed during that time. CEUs were also provided for certified and clinical staff. Providing lunch and CEUs proved to be good incentives for increased attendance. These courses also allowed our staff to obtain the 8 hours of required cultural competency for the year. BUDGET: Five (5) 2-hour trainings were provided: 3 x $225 = $ 675 2 x $600 = $1200 Total Cost: $1875 There were six (6) staff who were paid for attendance outside of their normal working hours for the five (5) 2-hour training sessions. Staff pay was calculated by taking an average hourly rate of of $35/hr. due to the two wage
Sitike	4650.75	5345.2	YEs	Yes	Yes	No	75%	Sitike utilized the grant monies to invest in a variety of trainings (Motivational Interviewing, SOGIE 101, Cultural Humility, etc.) dedicated to assisting our organization in nurturing and sustaining trauma-informed practices and improving our capacity to incorporate evidence-based practices into day-to-day resources. Through these initiatives, we've begun cultivating a healing environment by increasing organizational resilience and improving workforce skill and experience. 90% of our staff team participated in trainings that assisted them in developing new skills in the areas of trauma, co-occurring disorders, and cultural humility. 100% of our Board Members participated in cultural humility trainings and assessments. 100% of our interns participated in evidence-based and cultural humility trainings and assessments. ubject Matter Experts: $4,944.42 Center for Excellence in Nonprofits, Kristin Dempsey LMFT, California Institute for Behavioral Health Solutions, San Mateo County Pride Center, etc. Food for Trainings: $200.78 Printing and Copying: $200.00 Total Expense: $5,345.20

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Star Vista	4650.75	8000	No	No	Yes	No	75%	Funds utilized to provide assessment and training to enhance staff understanding of diversity, equity and inclusion; Engage outisde trainers $5000; Rental Space for 8 hours $1200; Printer Materials $600; Attendees/hr $2800; Total $9600
The Latino Commission	4650.75	5345.2	Yes	Yes	Yes	No	75%	Staff Training Conference and Retreat from December 13-15, 2021 outside the Bay Area. We used Presenters who were licensed mental health professionals, certified cultural program trainers, certified AOD trainers. Day 1 Group Dinner Day 2: All Day Group cultural activity Group Dinner Day 3 Morning Group Session (EBP training) Afternoon Group Session (Compliance, DMC-ODS updates) 75% of Direct Service Staff (9 of 12 direct service staff members or 75%) attended and received training to help facilitate and integrate our Behavioral Health Home, a trauma-informed SUD recovery service model. Staff participated in reviewing the agency DMC-ODS provider progress including trainings in EBPs and procedures for integrating care. Trainings on awareness and identifying co-occurring disorders that many of our clients have. Each staff member reviewed individual job descriptions and their continuing education requirements for the next year. Post evaluation shows 100% of staff improved their knowledge and expressed satisfaction with the Staff Training and Retreat. Budget for 9 staff attending: Transportation: Travel to conference $1,350.00 Group meals: Dinners, breakfast; lunch $1,795.20 Teaching Materials, Activity supplies, cultural activity entry fees: $600.00 Hotel: 2 nights (shared rooms) $1,600.00 Total Cost: $5,345.20 Grant received: $4,650.75 and $694.45 = $5345.20
Voices of Recovery	4650.75	5345.2	Yes	Yes	Yes	Yes	100%	The Leadership and WRAP training provided Voices staff with a simple and powerful process for creating the life and wellness they need and want. Staff was given the tools to create and maintain wellness. Through this evidence baed practice the staff was taught how to develop a daily plan to stay on track with your life and wellness goals. Resources to help them gain support and stay in control even in a crisis. The training have helped Voices to improve their capacity to implement more training throughout the county to address trauma and co-occuring disorders. Voices of Recovery trained nine staff as Certified WRAP Faciliators and six staff in Leadership skills. Leadership Trainer - 2650.00 Develop your own WRAP Training - 4 Staff - 34 hours = $556 Leadership Training - 6 Staff - 24 hours = $396 Certified WRAP - 5 Staff - 75 hours = $1125.00 Certification Manual - $129.00 X 10 - 1290.00 = Total = 6017.00 Voices paid the difference.

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YMCA Youth Servivce Bureaus	4650.75	5345.2	No	No	Yes	No	75%	This fiscal year we continued our partnership with RadicleRoot Collective and entered into Phase 2 contract with them to assist us in furthering our anti-racism work and progress towards racial equity and access work for both our client and staff populations. Phase 2 was $31,271.63 for this year and we used $5345.20 in MHSA grant money towards our contract with RRC. In phase 2 we had 3 separate trainings on Generative Conflict, numerous facilitations in establishing our White Accountabilty Group, which is mandatory for all white-itentified staff and trainees. We also had training and facilitation for our BIPOC-identified Affinity group held biweekly which is called YSB Culture Committee. phase 2 with RRC included 15 separate trainings and facilitation blocks. Staff provided feedback about this work in May, 2022 and was overwhelmingly positive and asked for contunued work with RCC, for a possilbe Phase 3, diving deeper into our affinity group spaces and entering into more trainings and work using Resmaa Manakem's VIMBAS and seminal work in healing racialized trauma. this is to benefit both our staff and the clients they serve. $5345.20 was spent towards recuperating our December 2021 second-half bill payment to Radicle Root Collective for Phase 2 work. MHSA grant money was received in two grant checks $4650.20 in March 2022 and $694.45 in April 2022.